STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Health Home Learning Collaborative

Chart Review Workbook

April 25th, 2023

This training is a collaborative effort between the Managed Care Organizations and Iowa Medicaid

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Agenda

- Introductions
  - Amerigroup – Katie Sargent, Samantha Hudson, Angelica Negron Morales, Veronica Jandura
  - Iowa Total Care – Lori Baker, Lindsey Hartman
  - IME – Wendy Peterson
- Chart Review Workbook……AGP/ITC/IME
- Health Home Case Study/Health Home Spotlight….Eyerly Ball, Pathways & First Resources
- Questions……..All
  - Coming Up
    - *May 15th – Annual InterRAI Training*
    - *June 26th – Comprehensive Assessment Process – Review of CASH & LOCUS/CALOCUS*
    - *July 17th – Risk Stratification*

What Will We Cover?

- Chart Review Workbook
  - Trends
    - Strengths
    - Areas of Improvement
      - Use of Approved Templates for Non-ICM Members
      - Most Frequently Missed Measures
    - Tips and Tricks Related to Documentation Submission
  - Interactive Small Group Activity
    - CRW Tool Practice with Mock Chart
  - Examples
  - Peer Sharing
    - How Do Health Homes Incorporate Feedback Results into Everyday Practice

Chart Review Workbook Trends

Strengths

- Increase in Scores 2021➡2022

Category	Improvement
Non-ICM	+2.1%
ICM	+9.07%
Overall	+5.68
Average change in overall score	+4.14%

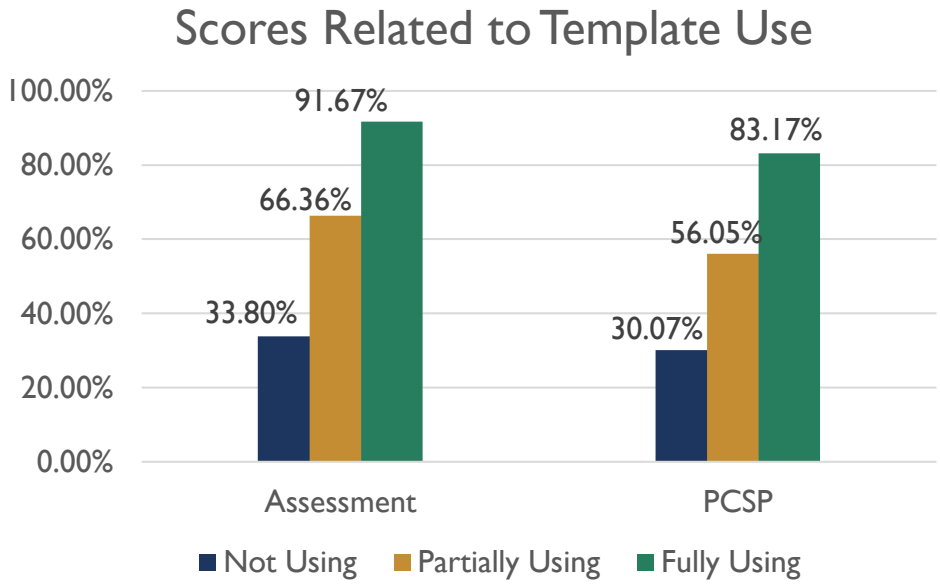
- Increase in Assessment & PCSP Scores from 2021➡2022

Category	Improvement
Non-ICM Assessment	+6.69%
Non-ICM PCSP	+7.44%
ICM Assessment	+16.03
ICM PCSP	+8.89%

Areas of Improvement

- Use of Approved Templates
  - Those providers who use approved templates for non-ICM members saw significantly higher scores than those who did not

Success with use of template	
CASH	Assessment section score - +38.46%
PCSP	PCSP section score +64.22%



Tips and Tricks For Documentation Submission

What We DO Need	What We DO NOT Need
Consent for enrollment specific to IHH	Consent that does not include IHH services
Current (within the review period) functional impairment and diagnosis	Notes from medical providers from previous years
Communication if you cannot meet due date to submit documents	PCSP and CASH/assessments from two years ago
All PCSPs/Assessments that cover the review period – regardless of completion date	Release of information (ROI)
All notes from nurse, care coordinator and peer support	
If assessment/PCSP meeting was scheduled a month before review period, please submit contact note documentation that shows assessment/PCSP meeting being scheduled.	
For FFS Members – must include IMPA cover sheet (refer to IMPA training guide for more information)	

Chart Review Workbook Interactive Activity

Most Frequently Missed Measures

Measure Number	Measure
	Enrollment Eligibility Section
13	The Health Home has shared tools provided by the MCO to assist the member (e.g.. Health Action Plan, welcome packet, health risk screener, assist with value added benefits, Healthy Rewards Program/My Health Pays, MCO member website / portal, transportation, telehealth, etc.).
	Assessment Section
26	During the review period, the Health Home encouraged the member to complete the Health Risk Screener or the screener was completed and incorporated into the assessment and care plan.
	Care Coordination Section
53	There is documentation of contact/ communication with the member's PCP within the review period.
54	There is documentation of contact/ communication with the member's providers to coordinate care.
55	There is documentation of conducting joint treatment staffing's with local providers, members, families and other social supports as indicated.
56	There is documentation of communication with providers on interventions/goals.
59	Integrated chronic disease management services have been coordinated and provided as necessary.
60	Member / Guardian has been provided education regarding when alternatives to ER would be appropriate. (i.e., PCP, urgent care, 24-hour nurse line)
63	If the member is diagnosed with hypertension, the health home provided education and coordinated with the PCP to address blood pressure. .
	Transition of Care Section
73	During the review period, the HH participated in the discharge planning process if member was inpatient at a hospital, PMIC, group care, or nursing facility
74	For transitional age youth, is there documentation of communicating with member regarding adult services and/or evidence of assisting member with transition to adult systems of care, during the review period.
75	There is documentation that medication reconciliation is completed during post-discharge follow-up visit.
76	Crisis plan was reviewed and updated as needed during or after the transition.
77	There is documentation of telephonic or face to face follow up after discharge from the hospital within 2 business days.
78	There is documentation of communication with the member regarding 7-day follow-up.
79	There is documentation of monitoring for potential crisis escalation and need for intervention following a transition in care.

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CRW Practice – Small Group Activity

- Break into small groups (mix IHHs together – will do after registration)
- Review the mock chart information provided
- Score the chart review workbook based on the information provided

Let's Discuss Measure 13

The Health Home has shared tools provided by the MCO to assist the member (e.g.. Health Action Plan, welcome packet, health risk screener, assist with value added benefits, Healthy Rewards Program/My Health Pays, MCO member website / portal, transportation, telehealth, etc.).

- Was this met? Y/N
- Why or why not?
- How could we improve this measure evidence?

Demo Mockchart | DOB: 08/01/2006 | Mock IHH
Sex: Male | Age: 17 years old | Tier: Non-ICM

IHH Contact Note – Non-ICM

Date: 03/08/2022
Writer: Madeup Caseworker, Care Coordinator
Type of Visit: Comprehensive Case Management
Location of Visit: Mock IHH Office
Core Service Provided: G0506

History and Demographics

Demo is a 17-year-old male who resides with his biological mother and younger brother in an apartment in Beebeetown, Iowa. His mother reports she had a smooth pregnancy and delivery. Demo was temporarily living with his grandparents in 2021 after an investigation determined biological parents were abusing substances in the home. His mother and father has since divorced, and his mother is sober and meets regularly with her sponsor. Department of Health and Human remains involved to monitor Demo and his brother's living situation and mother's sobriety. Member has struggled with aggression since a young age and was diagnosed with ADHD as a child. His mother described him as a lethargic child and bouts of physical aggression and was diagnosed with Type 1 diabetes when he was 10 years old. He continues to struggle with managing his weight and anger.

Member diagnoses:

- Attention-deficit hyperactivity disorder, unspecific type (F90.9)
- Essential (primary) hypertension (I10)
- Type 1 diabetes mellitus (E10)
- Obesity, unspecified (E66.9)
- Violent behavior (R45.6)

Upcoming appointments:

- 03/12/2022: BHIS, Demo Provider
- 04/07/2022: medication management, Dr. Psychiatrist
- 05/01/2022: diabetes follow up, Dr. Enrocrin
- 05/02/2022: primary care visit, Dr. Primarycare

Visit Outcome

Annual assessment and care plan meeting occurred with Demo and his mother. He continues to utilize services. Demo's mother shared that he continues to struggle in school and the school counselor discussed the possibility of him being expelled. He continues to show physical aggression with peers. Member's mother mentioned that Demo's blood pressure and A1C results were irregular at his last doctor visits. This care coordinator asked if member has any issues with transportation, member and his mother declined. Care coordinator let Demo and his mother know to reach out with any concerns. Care plan updated, goals reviewed.

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Measure 13 Example

CC provided information on services [redacted] can provide and explained that the member has a choice of other providers in the area, including [redacted] and [redacted]. The member chose to utilize [redacted] CC advised the member that IHS services are voluntary, and that they could opt out or speak to a member of the IHS staff if they had any disagreements or concerns.

CC spoke with member about individual and family peer support services and nurse care manager services available to them. Member declined this service.

Goals were communicated with member's primary care physician through mail.

Chronic condition self-management plan offered to be completed with the member with NCM as applicable.

Appropriate ED/PCP utilization reviewed with member and nursing lines/emergency contact information provided to member. Safety/crisis plan completed.

CC provided the following information to the member: MCO information, including member services contact information, MCO Nursing Line, and MCO value added benefits information; and IHS information, including contact information and emergency after-hours number.

Related Measure(s):

13. The Health Home has shared tools provided by the MCO to assist the member (e.g.. Health Action Plan, welcome packet, health risk screener, assist with value added benefits, Healthy Rewards Program/My Health Pays, MCO member website / portal, transportation, telehealth, etc.).

Let's Discuss Measure 26

During the review period, the Health Home encouraged the member to complete the Health Risk Screener, or the screener was completed and incorporated into the assessment and care plan.

Was this met? Y/N

Why or why not?

How could we improve this measure evidence?

Measure 26 Example

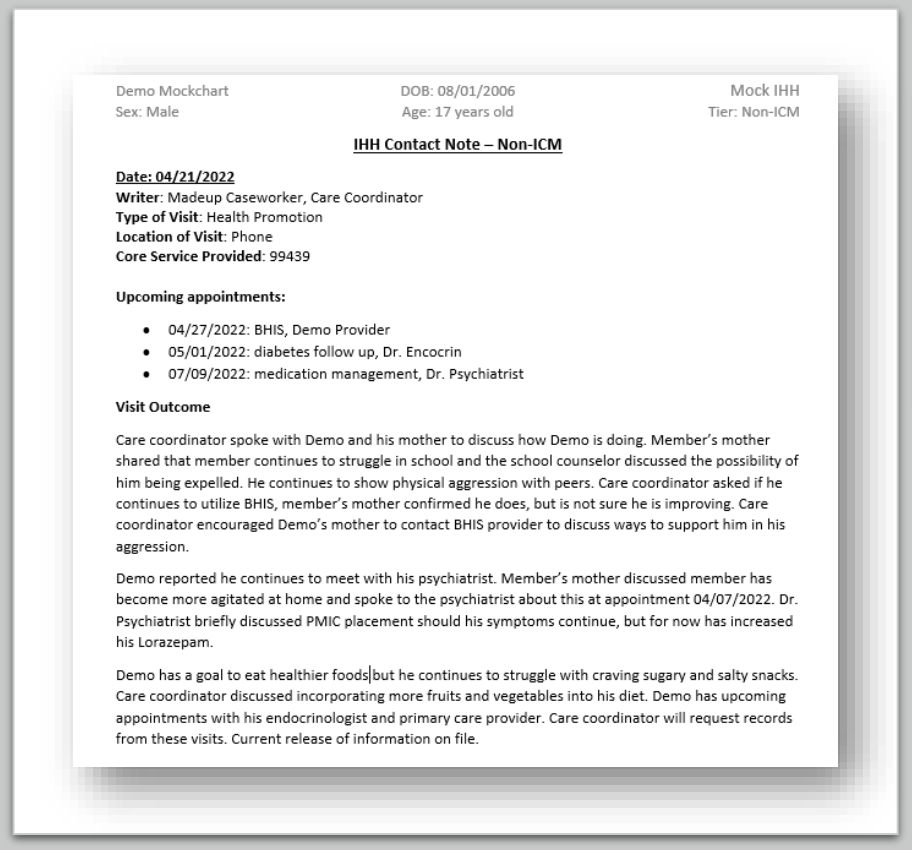
IHH Contact Note – Non-ICM

Date: 02/01/2022
Writer: Madeup Caseworker, Care Coordinator
Type of Visit: Health Promotion
Location of Visit: Phone
Core Service Provided: 99439

Visit Outcome

Care coordinator contacted Demo and his mother to see if they were able to complete the Health Risk Screener. Demo's mother confirmed they mailed it back yesterday, care coordinator will check Availity to obtain a copy and will discuss findings at next meeting.

Let's Discuss
Care Coordination Measures



Demo Mockchart | DOB: 08/01/2006 | Mock IHH
Sex: Male | Age: 17 years old | Tier: Non-ICM

IHH Contact Note – Non-ICM

Date: 04/21/2022
Writer: Madeup Caseworker, Care Coordinator
Type of Visit: Health Promotion
Location of Visit: Phone
Core Service Provided: 99439

Upcoming appointments:

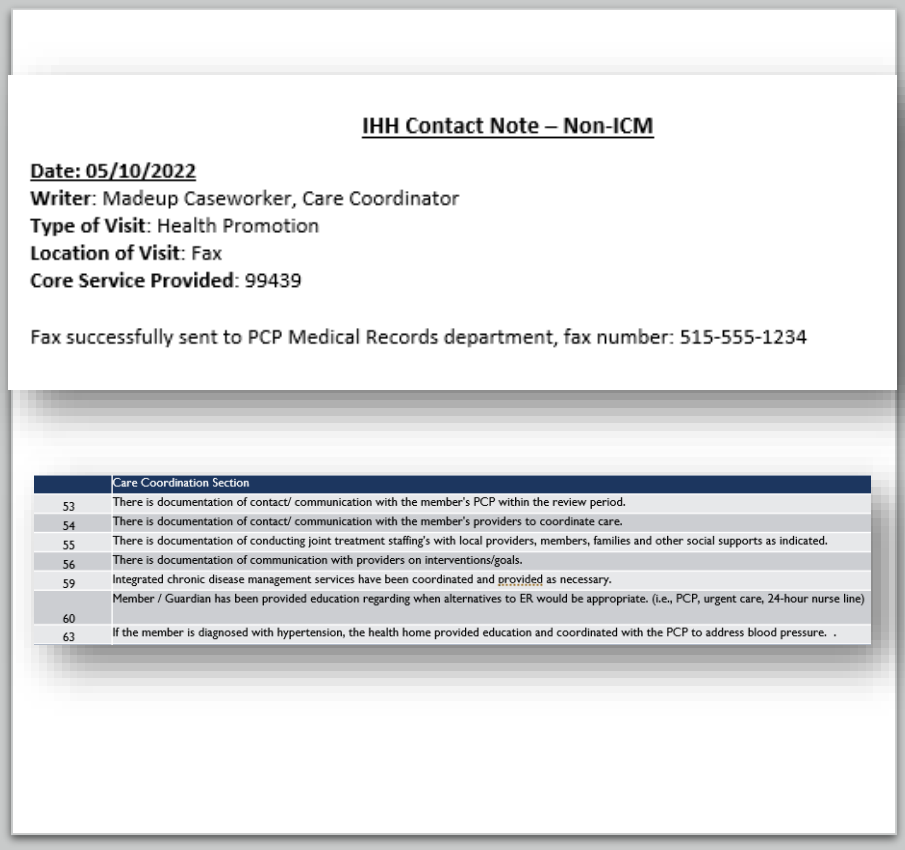
- 04/27/2022: BHIS, Demo Provider
- 05/01/2022: diabetes follow up, Dr. Encocrin
- 07/09/2022: medication management, Dr. Psychiatrist

Visit Outcome

Care coordinator spoke with Demo and his mother to discuss how Demo is doing. Member's mother shared that member continues to struggle in school and the school counselor discussed the possibility of him being expelled. He continues to show physical aggression with peers. Care coordinator asked if he continues to utilize BHIS, member's mother confirmed he does, but is not sure he is improving. Care coordinator encouraged Demo's mother to contact BHIS provider to discuss ways to support him in his aggression.

Demo reported he continues to meet with his psychiatrist. Member's mother discussed member has become more agitated at home and spoke to the psychiatrist about this at appointment 04/07/2022. Dr. Psychiatrist briefly discussed PMIC placement should his symptoms continue, but for now has increased his Lorazepam.

Demo has a goal to eat healthier foods but he continues to struggle with craving sugary and salty snacks. Care coordinator discussed incorporating more fruits and vegetables into his diet. Demo has upcoming appointments with his endocrinologist and primary care provider. Care coordinator will request records from these visits. Current release of information on file.



IHH Contact Note – Non-ICM

Date: 05/10/2022
Writer: Madeup Caseworker, Care Coordinator
Type of Visit: Health Promotion
Location of Visit: Fax
Core Service Provided: 99439

Fax successfully sent to PCP Medical Records department, fax number: 515-555-1234

	Care Coordination Section
53	There is documentation of contact/ communication with the member's PCP within the review period.
54	There is documentation of contact/ communication with the member's providers to coordinate care.
55	There is documentation of conducting joint treatment staffing's with local providers, members, families and other social supports as indicated.
56	There is documentation of communication with providers on interventions/goals.
59	Integrated chronic disease management services have been coordinated and provided as necessary.
60	Member / Guardian has been provided education regarding when alternatives to ER would be appropriate. (i.e., PCP, urgent care, 24-hour nurse line)
63	If the member is diagnosed with hypertension, the health home provided education and coordinated with the PCP to address blood pressure. .

Measures 13, 53 & 60

Describe the details of the IHH service provided today to the member:
CC attended team meeting at time and place chosen by [redacted].
[redacted] reports no cultural or communication needs.
The following paperwork was completed with the member: releases of information, consents, Rights and Privacy practices, health screener, DLA-20, CASH, InterRAI, Person-Centered Treatment Plan

CC provided information on services [redacted] IHS can provide and explained that the member has a choice of other providers in the area, including [redacted] and [redacted]. The member chose to utilize [redacted] IHS. CC advised the member that IHS services are voluntary, and that they could opt out or speak to a member of the IHS staff if they had any disagreements or concerns.

[redacted]

Goals were communicated with member's primary care physician through mail.

Appropriate ED/PCP utilization reviewed with member and nursing lines/emergency contact information provided to member.

CC provided the following information to the member: MCO information, including member services contact information, MCO Nursing Line, and MCO value added benefits information; and IHS information, including contact information and emergency after-hours number.

Related Measure(s):

13. The Health Home has shared tools provided by the MCO to assist the member (e.g.. Health Action Plan, welcome packet, health risk screener, assist with value added benefits, Healthy Rewards Program/My Health Pays, MCO member website / portal, transportation, telehealth, etc.).

60. Member / Guardian has been provided education regarding when alternatives to ER would be appropriate. (i.e., PCP, urgent care, 24-hour nurse line)

53. There is documentation of contact/ communication with the member's PCP within the review period.

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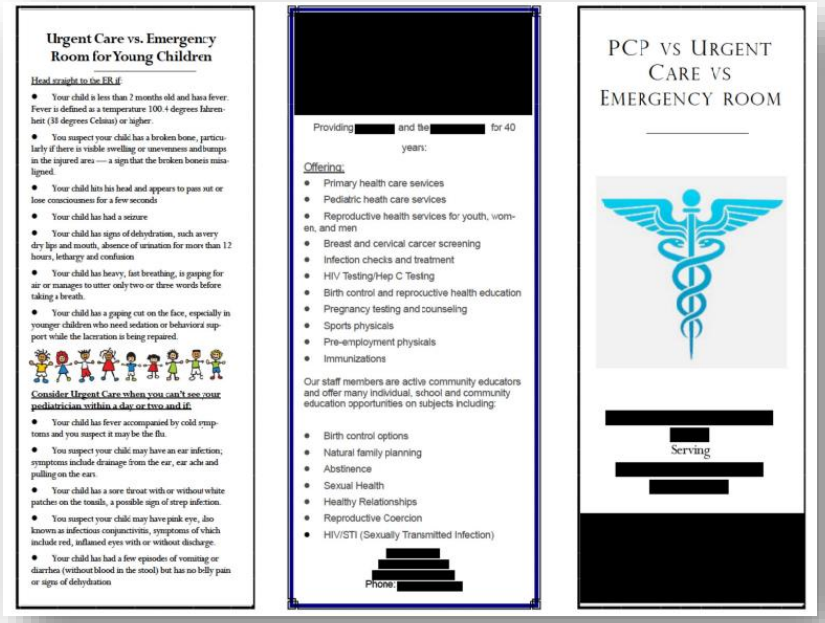
Measure 60 Example



Urgent Care vs. Emergency Room for Young Children

Head straight to the ER if:

- Your child is less than 2 months old and has a fever. Fever is defined as a temperature 100.4 degrees Fahrenheit (38 degrees Celsius) or higher.
- You suspect your child has a broken bone, particularly if there is visible swelling or unevenness and bumps in the injured area — a sign that the broken bone is misaligned.
- Your child hits his head and appears to pass out or lose consciousness for a few seconds
- Your child has had a seizure
- Your child has signs of dehydration, such as very dry lips and mouth, absence of urination for more than 12 hours, lethargy and confusion
- Your child has heavy, fast breathing, is gasping for air or manages to utter only two or three words before taking a breath.
- Your child has a gaping cut on the face, especially in younger children who need sedation or behavioral support while the laceration is being repaired.

Consider Urgent Care when you can't see your pediatrician within a day or two and if:

- Your child has fever accompanied by cold symptoms and you suspect it may be the flu.
- You suspect your child may have an ear infection; symptoms include drainage from the ear, ear ache and pulling on the ears.
- Your child has a sore throat with or without white patches on the tonsils, a possible sign of strep infection.
- You suspect your child may have pink eye, also known as infectious conjunctivitis, symptoms of which include red, inflamed eyes with or without discharge.
- Your child has had a few episodes of vomiting or diarrhea (without blood in the stool) but has no belly pain or signs of dehydration

[redacted]

Providing [redacted] and be [redacted] for 40 years:

Offering:

- Primary health care sevices
- Pediatric heath care sevices
- Reproductive health services for youth, women, and men
- Breast and cervical carcer screening
- Infection checks and treatment
- HIV Testing/Hep C Testing
- Birth control and reproductive health education
- Pregnancy testing and counseling
- Sports physicals
- Pre-employment physicals
- Immunizations

Our staff members are active community educators and offer many individual, school and community education opportunities on subjects including:

- Birth control options
- Natural family planning
- Abstinence
- Sexual Health
- Healthy Relationships
- Reproductive Coercion
- HIV/STI (Sexually Transmitted Infection)

[redacted]

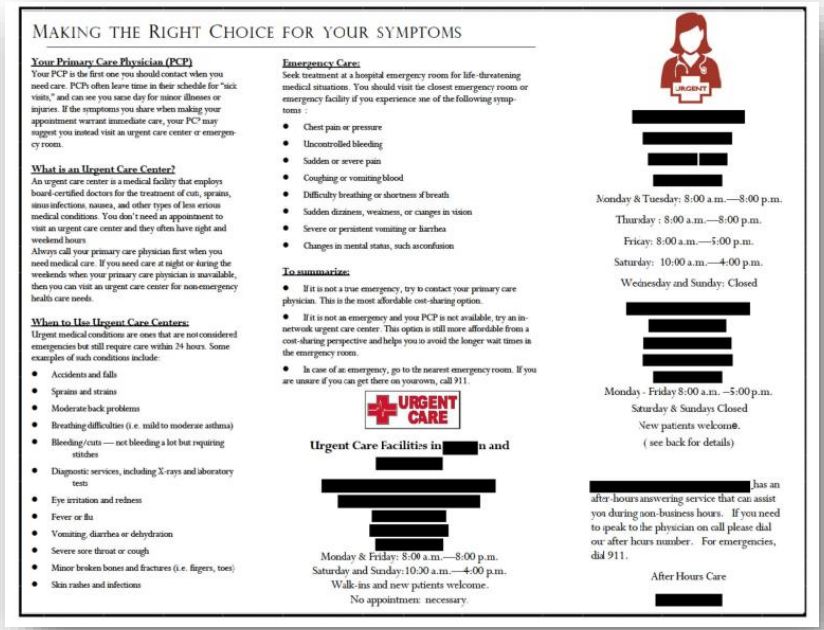
Phone: [redacted]

PCP vs Urgent Care vs Emergency Room

[redacted]

Serving

[redacted]



Making the Right Choice for Your Symptoms

Your Primary Care Physician (PCP)
Your PCP is the first one you should contact when you need care. PCPs often leave time in their schedule for "sick visits," and can see you same day for minor illnesses or injuries. If the symptoms you share when making your appointment warrant immediate care, your PCP may suggest you instead visit an urgent care center or emergency room.

What is an Urgent Care Center?
An urgent care center is a medical facility that employs board-certified doctors for the treatment of cuts, sprains, sinus infections, nausea, and other types of less serious medical conditions. You don't need an appointment to visit an urgent care center and they often have night and weekend hours.
Always call your primary care physician first when you need medical care. If you need care at night or during the weekends when your primary care physician is unavailable, then you can visit an urgent care center for non-emergency health care needs.

When to Use Urgent Care Centers:
Urgent medical conditions are ones that are not considered emergencies but still require care within 24 hours. Some examples of such conditions include:

- Accidents and falls
- Sprains and strains
- Moderate back problems
- Breathing difficulties (i.e. mild to moderate asthma)
- Bleeding/cuts — not bleeding a lot but requiring stitches
- Diagnostic services, including X-rays and laboratory tests
- Eye irritation and redness
- Fever or flu
- Vomiting, diarrhea or dehydration
- Severe sore throat or cough
- Minor broken bones and fractures (i.e. fingers, toes)
- Skin rashes and infections

Emergency Care:
Seek treatment at a hospital emergency room for life-threatening medical situations. You should visit the closest emergency room or emergency facility if you experience one of the following symptoms :

- Chest pain or pressure
- Uncontrolled bleeding
- Sudden or severe pain
- Coughing or vomiting blood
- Difficulty breathing or shortness of breath
- Sudden dizziness, weakness, or changes in vision
- Severe or persistent vomiting or diarrhea
- Changes in mental status, such as confusion

To summarize:

- If it is not a true emergency, try to contact your primary care physician. This is the most affordable cost-sharing option.
- If it is not an emergency and you PCP is not available, try an in-network urgent care center. This option is still more affordable from a cost-sharing perspective and helps you to avoid the longer wait times in the emergency room.
- In case of an emergency, go to the nearest emergency room. If you are unsure if you can get there on your own, call 911.

URGENT CARE

Urgent Care Facilities in [redacted] and

[redacted]

Monday & Friday: 8:00 a.m.—8:00 p.m.
Saturday and Sunday: 10:30 a.m.—4:00 p.m.
Walk-ins and new patients welcome.
No appointment necessary.

[redacted]

Monday & Tuesday: 8:00 a.m.—8:00 p.m.
Thursday : 8:00 a.m.—8:00 p.m.
Friday: 8:00 a.m.—5:00 p.m.
Saturday: 10:00 a.m.—4:00 p.m.
Wednesday and Sunday: Closed

[redacted]

Monday - Friday 8:00 a.m. –5:00 p.m.
Saturday & Sundays Closed
New patients welcome.
(see back for details)

[redacted] has an after-hours answering service that can assist you during non-business hours. If you need to speak to the physician on call please dial our after hours number. For emergencies, dial 911.

After Hours Care

[redacted]

Related Measure(s):
60. Member / Guardian has been provided education regarding when alternatives to ER would be appropriate. (i.e., PCP, urgent care, 24-hour nurse line)

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Measures 53 & 56 Examples

[redacted]

Integrated Health Services

[redacted]
Ph: [redacted]
Fax: [redacted]

May 26, 2020

Dear: Mercy One [redacted] Family Medicine,

Your patient, [redacted], Medicaid# [redacted] has enrolled with our Integrated Health Services (IHS) program. You have been identified as his/her Primary Care Physician to receive information regarding current risks, goals, and interventions. Our desire is to partner with you to help your patient reach their optimum overall health while reducing unnecessary emergency room visits and hospitalizations. IHS monitors care gaps, provides health promotion and chronic condition education, and makes referrals to providers and community resources. A Care Coordinator, a Nurse, and a Peer and Family Support Specialist, have been assigned to assist in meeting the identified goals below:

AREA OF RISK	Functional Status
GOAL	I want to become more independent
DESIRED OUTCOME	[redacted] will move to an appropriate setting and receive services with independent skill building

Please contact us with questions or needs you may have for your patient. We appreciate the work you do and look forward to collaborating with you.

Sincerely,

[redacted]

[redacted], RN
Integrated Health Services

Related Measure(s):

53. There is documentation of contact/ communication with the member's PCP within the review period.

56. There is documentation of communication with providers on interventions/goals.

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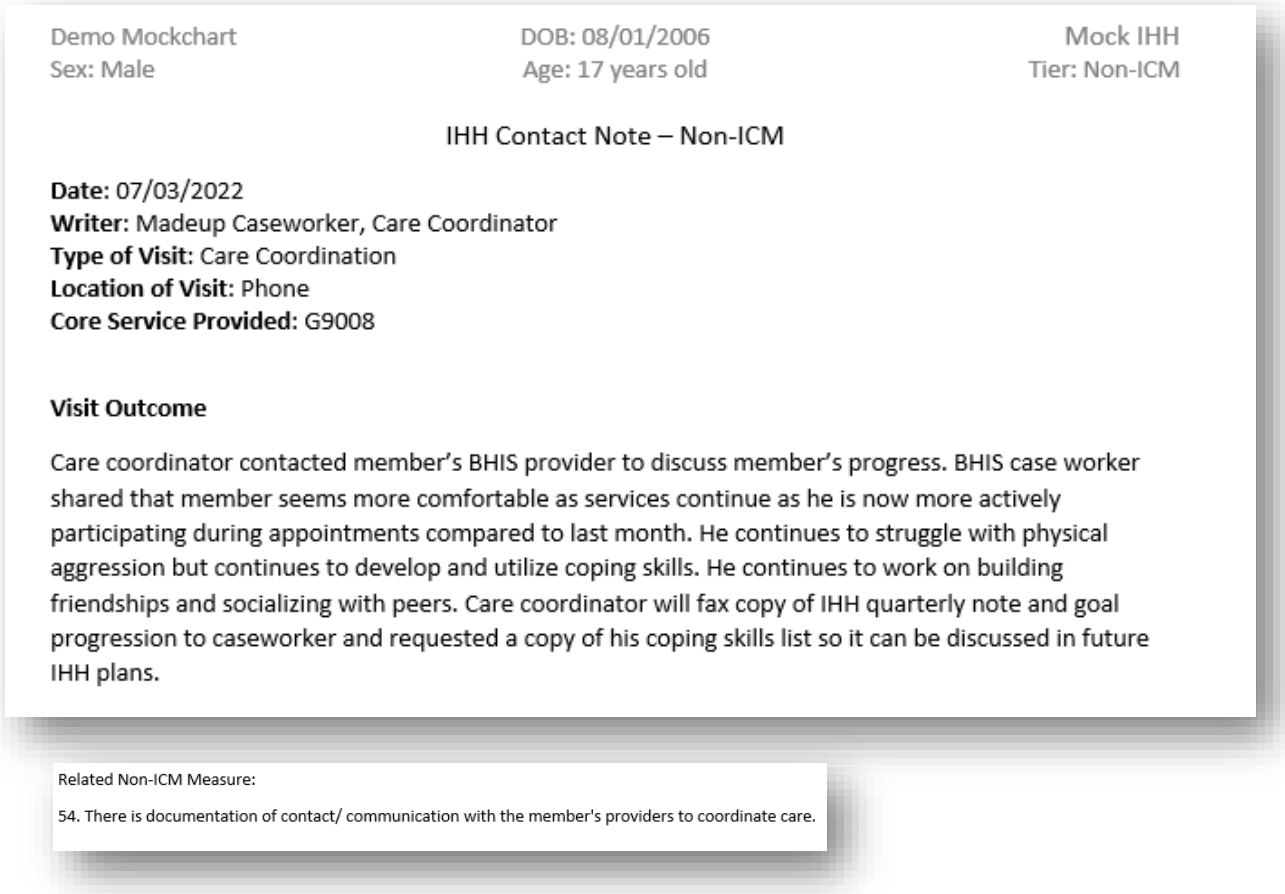
Measures 54



Demo Mockchart | DOB: 08/01/2006 | Mock IHH
Sex: Male | Age: 17 years old | Tier: Non-ICM

IHH Contact Note – Non-ICM

Date: 07/03/2022
Writer: Madeup Caseworker, Care Coordinator
Type of Visit: Care Coordination
Location of Visit: Phone
Core Service Provided: G9008

Visit Outcome

Care coordinator contacted member's BHIS provider to discuss member's progress. BHIS case worker shared that member seems more comfortable as services continue as he is now more actively participating during appointments compared to last month. He continues to struggle with physical aggression but continues to develop and utilize coping skills. He continues to work on building friendships and socializing with peers. Care coordinator will fax copy of IHH quarterly note and goal progression to caseworker and requested a copy of his coping skills list so it can be discussed in future IHH plans.

Related Non-ICM Measure:

54. There is documentation of contact/ communication with the member's providers to coordinate care.

Measures 55 Example

Demo Mockchart DOB: 08/01/2006 Mock IHH
Sex: Male Age: 17 years old Tier: Non-ICM

IHH Contact Note – Non-ICM

Date: 07/03/2022
Writer: Madeup Caseworker, Care Coordinator
Type of Visit: Care Coordination
Location of Visit: Phone
Core Service Provided: G9008

Visit Outcome

Care coordinator spoke with Demo and his mother to discuss how Demo is doing. Member's mother shared that member continues to struggle in school and the school counselor discussed the possibility of him being expelled. He continues to show physical aggression with peers. Care coordinator asked if he continues to utilize BHIS, member's mother confirmed he does, but is not sure he is improving.

Demo reported he continues to meet with his psychiatrist. Member's mother discussed member has become more agitated at home and spoke to the psychiatrist about this at appointment 04/07/2022. Dr. Psychiatrist briefly discussed PMIC placement should his symptoms continue, but for now has increased his Lorazepam.

Care coordinator asked Demo's mother if she would be open to having a meeting with as many of Demo's providers as possible to discuss potential ways of helping Demo as a team. Demo's mother was in agreement with this. Care Coordinator will reach out to Demo's BHIS provider, school counselor and psychiatrist for potential meeting times.

Date: 07/06/2022
Writer: Madeup Caseworker, Care Coordinator
Type of Visit: Care Coordination
Location of Visit: Phone
Core Service Provided: G9008

Care coordinator met with Demo, his mother, his BHIS provider, school counselor, and psychiatrist regarding Demo's recent increase in behaviors. All parties shared information on their observations of Demo over the last few weeks. IDT did not feel that PMIC placement was appropriate at this time, and team will request an increase in BHIS services. Current medications were not changed but he has an appointment with Dr. Psychiatrist in August and his progress will be discussed again then. Demo expressed that at times he struggles to control his anger because he becomes overwhelmed with tasks, and does not always know what will trigger him. The school counselor discussed meeting with member for 15 minutes every day after lunch to check in, and suggested a local therapist that specializes in ADHD compensatory strategies. Demo's mother agreed but expressed concerns about cost. Care coordinator will assist member's mother with contacting the provider and seeking a sliding pay scale, or discussing payment plans, and will explore local grants if needed.

Related Non-ICM Measure:

55. There is documentation of conducting joint treatment staffings with local providers, members, families, and other social supports as indicated.

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Measure 59 Example

Demo Mockchart | DOB: 08/01/2006 | Mock IHH
Sex: Male | Age: 17 years old | Tier: Non-ICM

IHH Contact Note – Non-ICM

Date: 05/10/2022
Writer: Example Nurse, RN
Type of Visit: Health Promotion
Location of Visit: Phone
Core Service Provided: 99439

Visit Outcome

RN spoke with Demo and his mother to discuss his health. RN reviewed care coordinator's meeting notes that show member reported doing well on his goal related to attending appointments but continues to struggle with healthy eating. RN also reviewed his most recent blood sugar readings which were elevated compared to last month's readings.

IDT has previously discussed ways for Demo to control his diabetes with a healthy diet, regularly checking his blood sugars, and exercise. RN asked Demo what he feels his biggest challenge is to meet his healthy eating goals. Demo replied that he does not mind checking his blood sugars as much as he used to but does not enjoy he taste of healthy foods. He said he usually eats something sweet or salty after every meal because the meals he's supposed to eat are "boring". RN discussed the possibility of member meeting with a dietitian to explore food items and meals he may enjoy eating that still support his hypertension and A1c goals. Demo and his mother agreed to this.

RN reviewed member's crisis plan including what to do when his blood sugar ranges are irregular, as well as the target ranges before and after meals as suggested by his endocrinologist. No changes to crisis plan or ranges, Demo declined needing it re-printed since last visit with RN.

Demo shared he had a visit with his endocrinologist last week to measure his A1c. RN to request records from this doctor, and forward include copy of member's diabetes crisis plan, his individualized blood sugar pamphlet, and notice of referral to dietician. Current release of information on file. RN to send referral to Healthy Dietitian Clinics.

Related Non-ICM Measure:

59. Integrated chronic disease management services have been coordinated and provided as necessary.

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Measure 63 Example

Demo Mockchart | DOB: 08/01/2006 | Mock IHH
Sex: Male | Age: 17 years old | Tier: Non-ICM

IHH Contact Note – Non-ICM

Date: 06/01/2022
Writer: Example Nurse, RN
Type of Visit: Health Promotion
Location of Visit: Phone
Core Service Provided: 99439

Visit Outcome

Blood Pressure Reading: 131/86

RN reviewed medical records received from member's primary care provider to include an increase in hypertension medication. RN asked Demo how he has adjusted to the change, and about maintaining a low-salt diet and staying hydrated throughout the day. Demo replied he didn't notice any negative side effects. His mother shared they have with the dietitian twice since referral was made last month and have continue to explore new meals for member to enjoy. Demo shared his favorite has been a cauliflower crust pizza, and was surprised he could find healthy goods he still likes. He shared that he has been playing baseball with his friends throughout the summer, RN commended him for socializing and exercising.

RN encouraged member to continue with the hypertension treatment plan his primary care provider has worked with him on. Demo and his mother had no other questions or concerns to discuss.

Related Non-ICM Measure:

63. If the member is diagnosed with hypertension, the health home provided education and coordinated with the PCP to address blood pressure.

IOWA HHS

Let's Discuss - Transition of Care Measures

Demo Mockchart | DOB: 08/01/2006 | Mock IHH
Sex: Male | Age: 17 years old | Tier: Non-ICM

IHH Contact Note – Non-ICM

Date: 06/29/2022
Writer: Madeup Caseworker, Care Coordinator, Example Nurse, RN
Type of Visit: Comprehensive Transitional Care
Location of Visit: Phone
Core Service Provided: 99426

Visit Outcome

Care coordinator received a voicemail from Mock Socialworker, a social worker, at Mock Hospital requesting a call back regarding Demo. Care coordinator completed a conference call with Mock IHH nurse and SW. SW confirmed member was admitted 06/26/2022 and the tentative discharge date is 07/01/2022 pending a safe discharge plan. Member was admitted for physical aggression and assaulting his mother, the police were called and member was admitted that evening. SW has concerns with member returning home without additional supports in place, and if a temporary PMIC stay may be appropriate. IHH team will discuss this with member's mother. SW will fax this writer all inpatient notes.

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Date: 06/29/2022
Writer: Madeup Caseworker, Care Coordinator, Example Nurse, RN
Type of Visit: Comprehensive Transitional Care
Location of Visit: Phone
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This RN contacted member's mother to discuss Demo's inpatient admission. Demo's mother explained that member had come home from school 06/26/2022 agitated and he said he was tired of the way he's treated by his classmates. When she tried to de-escalate he pushed her into the wall and her head started bleeding, and Demo began hitting the wall with his fists. She and her other son locked themselves in the bathroom while she called the cops. Demo banged on the door and continued to escalate. The cops were not able to deescalate upon arrival and he was transported to Mock Hospital. Demo's mother is concerned he will become physically aggressive when he returns home, but was not comfortable with him going into a PMIC or facility. Demo is turning 18 soon and may be a good candidate for the Habilitation program. RN explained the Habilitation program and application process, along with what services member could potentially access if approved. Member's mother was interested in this and agreed to begin this process. RN discussed an increase in BHIS to assist with member's transition, and member's mother will reach out to BHIS provider to coordinator this. She expressed she is comfortable with member returning home with this plan. Care coordinator has been alerted through system notification.

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IHH Contact Note – Non-ICM

Date: 06/29/2022
Writer: Example Nurse, RN
Type of Visit: Comprehensive Transitional Care
Location of Visit: Phone
Core Service Provided: 99426

This RN contacted Mock Hospital's SW to confirm Demo's mother is comfortable with him returning home and she will work with the BHIS provider to increase his services. RN explained member will be applying for the Habilitation program which, if approved, should provide member with additional supports and services. SW said member has been doing well but has had significant medication changes, all of which will be included in the fax he sent this afternoon.

IHH Contact Note – Non-ICM

Date: 07/10/2022
Writer: Madeup Caseworker, Care Coordinator
Type of Visit: Care Coordination
Location of Visit: Phone
Core Service Provided: 99426

Visit Outcome

Care coordinator contacted Demo and his mother to discuss how his transition back home has gone. Demo and his mother agreed that he is doing much better, and he has increased BHIS to three times a week. Demo's mother has a meeting with his school to review his behavioral plan. Care coordinator discussed if Demo had ever considered therapy, Demo was not opposed to this and neither was his mother. Care coordinator encouraged Demo and his mother to explore this with his psychiatrist to see if they had any suggestions on providers in the area. Demo had no other questions at this time. Demo's mother shared that he has a follow up visit with his primary doctor scheduled for 07/11/2022.

	Transition of Care Section
73	During the review period, the HH participated in the discharge planning process if member was inpatient at a hospital, PMIC, group care, or nursing facility
74	For transitional age youth, is there documentation of communicating with member regarding adult services and/or evidence of assisting member with transition to adult systems of care, during the review period.
75	There is documentation that medication reconciliation is completed during post-discharge follow-up visit.
76	Crisis plan was reviewed and updated as needed during or after the transition.
77	There is documentation of telephonic or face to face follow up after discharge from the hospital within 2 business days.
78	There is documentation of communication with the member regarding 7-day follow-up.
79	There is documentation of monitoring for potential crisis escalation and need for intervention following a transition in care.

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Transition of Care Form

Hospitalization, Inpatient, Facility Placement Protocol

	Description	Staff Initials	Date
1.	Once notified of admission, contact the member/guardian/authorized representatives to discuss wellbeing, health, any support needed, and returning to the community if applicable.		
2.	Contact facility to discuss: - Admit date: _____ - Admitting diagnoses: _____ - Discharge date: _____ - Medication changes: _____ - Recommendations needed for successful discharge: _____ _____ - Date of discharge meeting (if one is held): _____		
3.	Contact related providers to discuss admission, potential discharge recommendations, and any appointments as needed.		
4.	If member is age 16-18, communicate with member/guardian about transitioning to adult systems of care.		
5.	Make referrals to appropriate services. Circle referrals made or services that are already in place: Medication Management, Therapy, BHIS, PMIC, LTSS Other_____		
6.	Attend/facilitate discharge meeting and obtain discharge paperwork including medications.		
7.	CC, FPSS or Nurse, follow up with member within 2 days of discharge (phone or face to face) to discuss any immediate concerns including safety or barriers to discharge orders.		
8.	Ensure a 7-day follow-up appointment with PCP or MHP is scheduled, and any barriers are addressed. Schedule any addition follow up appointments as needed. Provider: _____ Date: _____ Provider: _____ Date: _____ Provider: _____ Date: _____ Provider: _____ Date: _____		
9.	Review care plan and add/review crisis plan(s) applicable to reason for admission. Monitor crisis plans and member's symptoms for escalation.		
10,	Follow up with PCP or MHP to ensure that 7-day follow-up was attended, and medications are reconciled. _____Yes _____ No		
11.	Comments:		

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Health Home Spotlights

- Eyerly Ball
- Pathways
- First Resources

Questions?

Thank you!