A Day in the Life of a Health Home Team

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Objectives:

1. Describe the five main staff roles in a health home
2. List the key functions for each
3. Share examples of how the team functions in an interdisciplinary fashion
Stay engaged!

Please use the chat box at any time with a comment, a question, something you wonder about? Let’s make this alive as we are all in the learning curve.
Ohio Health Home: Health Promotion

Chronic disease self-management
- Tobacco cessation
- Weight management
- Nutritional counseling
- Exercise and fitness
- Preventive services and screenings
Team Leader

> Strong health management background, data management, managed care background.

> Has an ability to champion the health home services, motivate and educate other staff members
Provide administrative and clinical leadership and oversight to the health home team, and monitor provision of health home service.

Monitor and facilitate consumer identification and engagement, completion of comprehensive health and risk assessments, development of care plans, scheduling and facilitation of treatment team meetings, provision of health home service, consumer status and response to health coordination and prevention activities, and development, tracking and dissemination of outcomes.
Embedded Primary Care Clinician

- Provide health home service including identification of consumers, assessment of service needs, development of care plan and treatment guidelines, and monitor health status and service use.

- Provide education and consultation to the health home team and other team members regarding best practices and treatment guidelines in screening and management of physical health conditions as well as engage with, and act as a liaison between, the treating primary care provider and the team.

- Meet individually as needed with care managers to review challenging and complex cases.

- It is preferred, but not required, that the embedded primary care clinician also functions as the treating primary care clinician and thus may hold dual roles on the health home team.
Accountable for overall care management and care coordination, and both provide and coordinate all of the health home service.

Responsible for overall management and coordination of the consumer's care plan, including physical health, behavioral health, and social service needs and goals.

Conduct comprehensive assessments and develop care plans.

Conduct case reviews on a regular basis.
Responsibilities:

Assist and support the care managers with:

» care coordination,

» referral/linkage,

» follow-up,

» consumer, family, guardian and/or significant others support and

» health promotion services.
In the chat box type in your biggest question about a day in the life of a health home? What is hardest for you to figure about in terms of service delivery, the day to day, as you prepare to work in this new service model?
So how do we start?
One slice of the team

- Sally: Team Leader
- Susan: Embedded PCP
- Steve: Care manager
- Stan: QHHS
Monday morning

- Sally: looks at the new referrals, meets with Steve and two other care managers to talk about the week, new referrals, plans for individual team meetings later in week.
- Steve: meets with Sally, gets ready to go out to meet Ms. Harrison who has been assigned to his team
- Susan: calls Sally at 10 to check in, arrange for team meeting that week, respond to emails from Friday
- Stan: makes his daily wellness check up calls, plans his day based on those calls
- Sally, Steve and Stan and rest of Steve’s team: 15 minute morning huddle via conference call mid morning to review what happened over the weekend, highlight high priorities for the week
> Sally: Reviews registry data to look for trends in outcomes,

> Steve: visits Ms. Harrison, does assessment, works on initial plan with her, lets her know that Stan will be seeing her tomorrow. Explains HH services and team approach.

> Stan: finds out that Mr. Smith hasn’t done his blood sugar checks over the weekend, sounds groggy on the phone so starts with a visit there.

> Steve and Stan meet for lunch: Steve talks about some of the outcome data for people Stan is working with.
Monday afternoon

- Sally: meets with office staff, receptionists to update on health home development, get their input on what’s working and what isn’t.

- Susan: calls a colleague to talk about Mr. Sylvester who isn’t getting better, plans for grand rounds at hospital on Wednesday

- Steve covers for Samantha (another case manager) so she can go along to a doctor’s appointment with Ms. French because the team discovered the combination of her trauma and her bad experiences was getting in the way of her getting care.

- Stan: goes with Mr. German to the local park, walks and talks, makes sure he checks blood sugar before and after.

- Team has a meeting at the end of the day: look at data trends, run quickly through all team members, PCP attends via skype, psychiatrist meets with team as well.
Ready, Set, GO!!

> How are we doing with your questions?

What is still hanging for you?
General Principles:

> Flow through the team
> Bringing everyone on board with the team approach
> Everyone has a role in tracking data and paying attention
> Flexibility, pro-active planning
> Regular supervision
> Planned agendas for team meetings
> Open conversation about role definitions and responsibilities
> Team leader attends to the change process
Early Successes

- Early detection in kids of physical health issues
- Greater ability to think pro-actively and incorporate telephone based strategies
- Emphasis on wellness everywhere: staff and participants
- Increasing community connections
- Changes in adults exercise, weight, symptom management
- Positive energy among staff