



# HEALTH HOME: REGIONAL HEALTH FAMILY MEDICINE RESIDENCY CLINIC



## CASE STUDY:

- **About Ms. Kathy Jedlicka and Regional Health Family Medicine Residency Clinic**
- **What populations do you serve in your clinic?**
- **How do patients qualify for the Medicaid Health Home Program?**
- **What does care look like for a Medicaid Health Home patient at the clinic?**
- **What are the benefits of this model of care?**
- **What are some challenges with this model of care?**
- **How does the clinic get reimbursed for Health Home services?**
- **What kind of reporting is required for Health Home clinics?**
- **What advice do you have for other facilities that are considering a Health Home model or another form of team-based care?**



## About Ms. Kathy Jedlicka and Regional Health Family Medicine Residency Clinic

In this interview, we talk with Ms. Kathy Jedlicka, RN, Care Manager for the South Dakota Medicaid Health Home program at Regional Health Family Medicine Residency Clinic about how the clinic operates as a Medicaid Health Home.

Regional Health Family Medicine Residency Clinic is located in Rapid City and provides comprehensive care for all patients, from childhood to senior years. The Family Medicine Residency Program is a three-year program for graduates of medical school who want to practice family medicine. Residents work hand-in-hand with experienced family medicine physicians and other physician mentors to provide quality health care to patients in both clinical and hospital settings.

*Thank you to Kathy Jedlicka for sharing this story.*

## What populations do you serve in your clinic?

Ms. Jedlicka explains that her clinic is located in a part of town where they see a lot of low socioeconomic status patients and that they get a lot of walk-ins from this area. Kathy says the clinic serves all patients, from birth to death and a portion of these patients qualify to be Medicaid Health Home patients.

## How do patients qualify for the Medicaid Health Home Program?

The state determines the list of Medicaid recipients who qualify for the Health Home program, which includes having two or more chronic medical conditions or one mental health condition. Patients of the clinic who are on that list from the state are assigned to a faculty physician who is a primary care provider with the state of South Dakota. The clinic receives the case listing from the state monthly with the list of patients who are attributed to the clinic who are eligible to be Health Home participants. On average, this clinic is attributed 120 patients per month.

## What does care look like for a Medicaid Health Home patient at the clinic?

As a residency clinic, there are usually 4 to 5 resident physicians working during the day so Medicaid Health Home patients can usually get an appointment the same day. "Patients appreciate that they can be seen that day," says Kathy. The resident physician sees the patient, then the resident physician provides their plan of care to a board certified faculty physician. There is a pharmacist and a dietitian that can be pulled in as part of the care plan, and of course, the nursing staff is essential to patient care. Kathy is the care manager who provides education to patients, connects them to outside services, and communicates with all members of the care team. "We work very well as a team," says Kathy. "We communicate very well between all specialties."

Kathy explains, “I do a lot of education to the patients...because, ya know, they’ll wake up in the morning and have a snuffle or a sore throat. They think they have to go to the emergency room for that. So I’ve done a lot of education on that.” Because they are a Health Home patient, they can often be seen the same day or first thing the next morning. Kathy sees between 1 to 8 patients in the clinic daily.

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**“It’s all about education and making them feel like they have someone that cares about them,” says Kathy. “I really want the patient to feel special and cared for.”**

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## What are the benefits of this model of care?

At a typical doctor’s appointment, the patient can feel rushed through the appointment. However, a Medicaid Health Home patient gets to meet with a care manager like Kathy at nearly every visit. The care manager can go over the plan of care, answer questions and explain things in more detail, such as how to take different medications and what to expect when they take that kind of medication. Kathy explains, “We have a lot of patients that don’t know how to read so we have to come up with innovative ways to help them understand what the physician has to tell them.”

Kathy shares a story of one particular patient who is unable to swallow and was on a feeding tube. All of his medications were in pill form and he had to crush everything, which would often get caught in the feeding tube. Kathy realized many of those medications came in liquid form and was able to get his medications switched from pill to liquid form. This made a world of difference to the patient. “It’s just little things like that make that patient’s care a little easier and a better quality of life. This patient regards me as his best friend because I got all of his medications changed over to a liquid form so he could take them through a feeding tube... For myself, it was no big deal, but for him, it changed his world, taking that little extra step.”

## What are some challenges with this model of care?

Because this is a residency clinic and the resident physician needs to get their plan of care approved by the faculty physician, the appointment can take a little longer and there can be a lot of waiting time for the patients in the exam rooms. However, this provides a critical opportunity for the care manager to meet with the patient. Kathy explains, “Those patients tell me way more things than what they would have time to tell the physician. If I can pass anything on to the physician to make that plan of care better, that’s what I do.”

## How does the clinic get reimbursed for Health Home services?

The state reimburses the Health Home clinic based on a per-member, per-month reimbursement for the Medicaid recipients who qualify. Patients are placed into a tier system based on their condition(s). Tier 1 patients are typically children with a chronic condition; Tier 2 & Tier 3 patients are assigned based on the severity of their illness; Tier 4 patients have several comorbidities. Each tier is associated with a different amount of reimbursement per patient.

The state has 6 core measures that Medicaid Health Home clinics are encouraged to meet with their patients to ensure that patients are coming into the clinic, controlling their conditions, and getting the support they need.

*The Six Core Services are:*

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care
- Patient and family support
- Referrals to community and support services

Health Home clinics need to meet one of the six measures on every Health Home patient that is attributed to the clinic. If the clinic can show that at least one of these measures was met on each patient, the state will provide that per-patient per-month reimbursement according to patients’ assigned tier.

Kathy explains that it behooves the clinic to get these core services met for their patients so they can get the reimbursement, but she looks at it as she’s helping patients live a higher quality life because patients can better understand their care plan, they know that someone cares about them, and that someone is helping them monitor their condition.

“It is kind of an incentive for the clinics because we’re getting this money from the state to help manage these patients to make sure that they understand what their disease conditions are. Of course, the goal for the legislative side is to cut the cost for those Medicaid patients. And so by doing that, we’re hoping that we can keep them out of the hospitals and out of the emergency rooms or using the emergency room for things that a primary care physician’s office could certainly be handling during normal business hours.”

## What kind of reporting is required for Health Home clinics?

On a quarterly basis, the clinic sends a report to the state showing that they’ve completed at least one of the six core services for each patient. The state also requires clinics to submit an outcomes measures report twice a year. It also shows if the clinic is screening patients for depression, substance abuse, hypertension, diabetes, etc. The state then provides the clinic with a report about how the clinic is performing and how that clinic compares with other Health Home facilities in the state.

## What advice do you have for other facilities that are considering a Health Home model or another form of team-based care?

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**Kathy says, “Go for it! The more you can get your patients engaged and involved in their own health care, the better the outcomes you’re going to have for your patients....If you can give [a patient with an uncontrolled chronic condition] a better quality of life, ya know, life is good.”**

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*To learn more about how Regional Health Family Medicine Residency Clinic operates as a Medicaid Health Home, you can contact Kathy Jedlicka at [Kjedlicka@regionalhealth.org](mailto:Kjedlicka@regionalhealth.org).*



# HEALTH HOME: BROWN CLINIC



## CASE STUDY:

- About Ms. Kelsey Raml, Ms. Joan Friedrichsen, and Brown Clinic
- What are the benefits of the Health Home model for providers?
- What are the benefits of the Health Home model for patients?
- What are some challenges you've experienced with this model?
- What stakeholders were involved in making decisions about this model?
- What advice would you give to other facilities?
- How does the clinic get reimbursed for Health Home services?



## About Ms. Kelsey Raml, Ms. Joan Friedrichsen, and Brown Clinic

In this interview, we talk with Ms. Kelsey Raml and Ms. Joan Friedrichsen. Kelsey is an RD doing nutrition education and counseling for patients in the clinic. With the Medicaid Health Home program, Kelsey's role is like that of a health coach, promoting healthy behaviors among patients. She also handles data management and reporting for the Health Home program.

Joan is an RN and serves as a link between Medicaid recipients (patients) and providers. When a patient comes in to see a provider, Joan attends those visits whenever possible and is both an advocate and case manager for the patient. Joan helps educate patients so they can better adhere to their treatment plan.

Brown Clinic is an independent, physician-owned practice with two locations in Watertown. It has over 100 employees, including 19 physicians and 7 non-physician clinicians (nurse practitioner, physician's assistant, etc.). Primary care is the clinic's central focus, and the Medicaid Health Home program is a subset of services provided by Brown Clinic. The clinic also offers services in internal medicine, geriatric care, pediatrics, general surgery, obstetrics/gynecology, podiatry, laboratory services and in-house radiology.

*Thank you to Kelsey Raml and Joan Friedrichsen for sharing this story.*

## What are the benefits of the Health Home model for providers?

"Providers really appreciate the extra help [from Kelsey and Joan] with educating and coaching those patients," explains Kelsey. Kelsey and Joan can help connect patients to additional resources or community services. Providers also appreciate the extra care taken so their patients can be healthier and more compliant. It truly is a multidisciplinary approach to care management.

## What are the benefits of the Health Home model for patients?

Joan explains, "I usually try to go to the patient's office appointments with the physicians because sometimes [the recipient] becomes very overwhelmed with the amount of information, so I can be the advocate between the physician and the recipient and the family." Joan is able to spend extra time with patients to answer their questions, provide education, and connect them with community services. By attending appointments with patients, Joan is able to build trust and rapport, which helps patients feel less nervous and anxious when they come to the clinic. "Sometimes they give me too much information about their personal lives, but it's all part of it because it's not just about their health, it's about their everything from mental to emotional to physical wellbeing," says Joan.

**"I think it's very comforting for our recipients that there's someone there for them. We have several recipients whose family does not live in the vicinity and [the recipients] are very happy that there is someone here to be their advocate."**

## What are some of the challenges you've experienced with this model?

As far as the model itself, there have not been any major challenges. "In the beginning setting it up, we had a few challenges with trying to figure out the direction to go with our documentation and the learning curve of any program," Joan shares.

Kelsey explains, "One thing that's really nice about us at Brown Clinic is that the administration and physicians are fully supportive of the program and of quality efforts, so it was never an issue to get us what we needed or to work with us. They've all been very supportive of it."

## What stakeholders were involved in making decisions about this model?

Brown Clinic has an Administrator, Executive Board, Chief Medical Officer, general partner who oversees financials, directors of patient care, nursing, etc., and a Quality Committee. Those partners recognized that the Medicaid Health Home program was one worth the investment. Once the decision was made to become a Health Home provider, then it was just a matter of getting the right staff and the right processes in place.

## What advice would you give to other facilities?

Kelsey and Joan agree: "Have your physicians on board. If staff sees that physicians are invested and want to do this then it's a whole lot easier to follow suit. But if [the physicians] are not on board or promoting it, then staff won't want to be as apt to do it." Furthermore, "We would recommend doing the Medicaid Health Home program because it's a great program not only for the patients but for providers to help us provide better, more quality care to our patients."

*To learn more about how Brown Clinic operates as a Medicaid Health Home, you can contact Kelsey Raml at [Kelsey.Raml@brownclinic.org](mailto:Kelsey.Raml@brownclinic.org) or Joan Friedrichsen at [Joan.Friedrichsen@brownclinic.org](mailto:Joan.Friedrichsen@brownclinic.org).*