

HEALTH HOMES PROGRAM UPDATE



8/12/2014

Robert G. (Bob) Bethell Joint Committee on
Home and Community Based Services and
KanCare Oversight

HEALTH HOMES GOALS

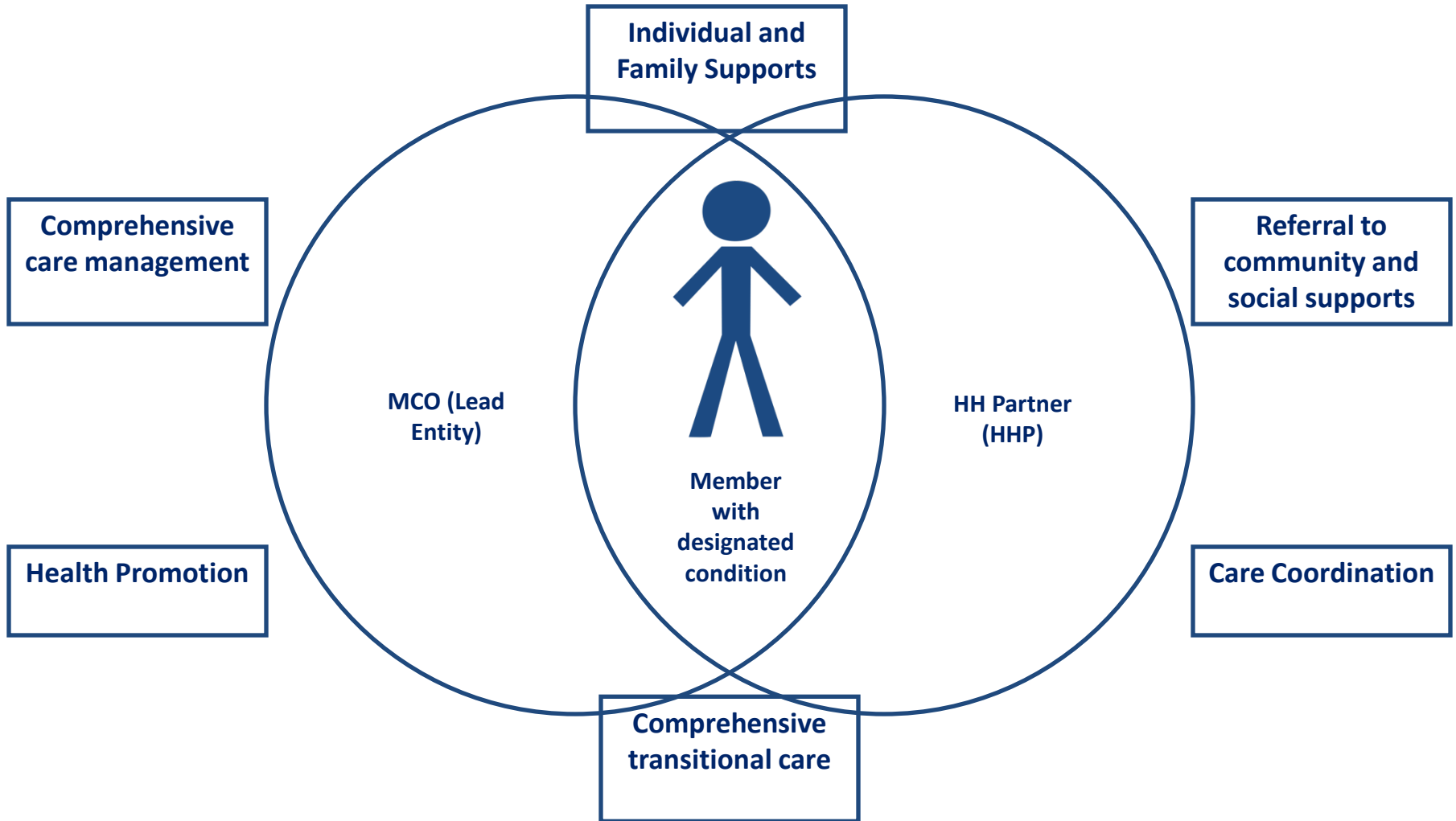
Kansas has set four goals for Health Homes:

- Reduce utilization associated with avoidable (preventable) inpatient stays
- Improve management of chronic conditions
- Improve care coordination
- Improve transitions of care between primary care providers and inpatient facilities

TRANSFORMATIVE PROCESS

- Changing how the system deals with patients – whole person
- Encouragement of local collaborations
- Moving more providers to robust use of HIT
- Bundled payment for a set of services that encourage and improve health
- Active engagement of patient in self-management of conditions

KANSAS MODEL



IMPLEMENTATION UPDATE

- Health Homes for people with serious mental illness (SMI) implemented July 1, 2014
- State Plan Amendment approved by CMS July 28, 2014
- 25,814 letters mailed to potential members first week in July, 2,237 have opted out
- Letters go out every month to newly identified members

IMPLEMENTATION UPDATE

- State Health Homes Manager hired
- Services began August 1, 2014
- Weekly implementation calls held with stakeholders every Thursday at 10:00
- Health Action Plan (HAP) training beginning in late August
- Learning Collaborative launches in September

ONE SMI HEALTH HOME

- Connections for Life
- High Plains Mental Health Center
- Serving 20 counties in NW Kansas
- Scheduled 100 appointments August 1 with HH members to begin assessment and Health Action Plan development

Hella!

My name is Daphne Brown, manager at Connections for Life, and I am thrilled to be a part of this new approach to healthcare known as a Health Home. The purpose of Connections for Life is to help KanCare members utilize all available resources to achieve their personal health goals. I took the position with Connections for Life because I love to empower and support others as they strive toward their own personal goals.

At Connections for Life, my staff and I will be able to help you receive the medical care that you need, access all of the resources at your disposal, and achieve the goals that you have for your own health and wellbeing. We can't wait to meet you and help you identify your current strengths and goals and to help you to develop a plan to reach those goals.



hope to see you soon!
Daphne Brown



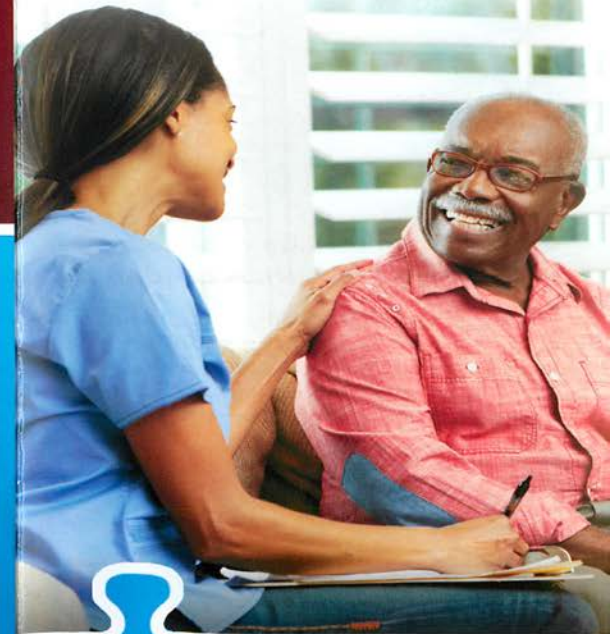
Connections for Life is a KanCare Health Home and is a service of High Plains Mental Health Center.

The term "health home" refers to a new Medicaid service that provides coordination of physical and behavioral health care for people with chronic conditions. Health homes focus on the whole person and managing his or her conditions in order to be as healthy as possible. The Health Home facilitates communication among various healthcare providers to insure that all of a patient's needs are addressed in a comprehensive manner.

for more information

KanCare Health Home Program
www.kancare.ks.gov/health_home.htm

Connections for Life
www.connectionsks.com
(785) 621-2261



A Service of
HIGH PLAINS MENTAL HEALTH CENTER



Connections for Life connects you, as a member, with the medical services and resources needed to achieve your personal health goals.

We provide you with health education opportunities and support that can help you to maintain or improve your health and quality of life. We can help in areas such as nutrition, personal fitness, and prescription maintenance, as well as direction and support in making lifestyle changes such as smoking cessation or weight loss. Our mission is to connect you with all of the resources that you may need to reach your personal health goals, big or small.

membership

- Membership is offered to Medicaid clients living with a chronic medical condition that requires regular maintenance.
- Membership is free to those who qualify
- All services provided by Connections for Life are provided at no additional cost to members

online resources

- KanQuit** – smoking cessation
- Walk Kansas** – personal fitness
- MyStrength** – mental health support

local resources

- Access to computers for online tools
- Access to Educational Materials

the process

- As a member you will be assigned a care coordinator who will work with you and existing primary care provider (*doctor, physician's assistant, or nurse practitioner*)
- You and your care coordinator will develop specific goals and a Health Action Plan
 - You have control over which goals take priority in your Health Action Plan.
 - Your Health Action Plan will help you pursue these goals step-by-step
 - We will help you use the resources provided by your MCO to help you reach your goals
- You will meet with your care coordinator periodically to discuss progress and make adjustments to your Health Action Plan

we can help you

- Maintain your pharmaceutical prescriptions
- Schedule appointments with doctors and specialists
- Apply for special services through your MCO
- Secure transportation to and from appointments
- Understand medical instructions and even attend appointments if necessary
- Develop strategies to improve your overall well-being

IDD TCM AND HEALTH HOMES

- CMS does not allow duplication of service or payment for people in Health Homes.
- CMS views targeted case management (TCM) and some of the six core services within Health Homes as similar; therefore, people in Health Homes cannot receive both TCM and HH services.

STATE RESPONSE

- Recognizes that people with intellectual or developmental disabilities (I/DD) have strong relationships with their TCM and that there are many providers of this service.
- Incorporates almost all of the activities in the definition of TCM into the definitions of the six core HH services.
- Requires HHP to contract with IDD TCM provider to be part of HH team
- Guarantees a PMPM of no less than \$137.32 per month for TCM providers serving members with I/DD in an SMI Health Home

CC HEALTH HOMES DELAY

- Health Homes for people with asthma or diabetes who are also at risk for another chronic condition (CC) have been delayed
- CMS requires a choice of HHPs - must have at least two HHPs willing to serve each type of target population– SMI and CC – in each county
- Insufficient number of primary care providers interested

CC HEALTH HOMES DELAY

- All CMHCs indicated interest in serving the SMI population and about half of them also were willing to serve the CC population
- 10 FQHCs were ready to serve the CC population July 1, along with two safety net clinics, three hospitals, three home health agencies
- 19 Local Health Departments expressed interest, but most wished only to subcontract
- A large number of I/DD providers also submitted tools, but most appear to be interested in serving as HHPs only for their existing consumers

CC HEALTH HOMES DELAY

- Developing map of needed capacity to serve were the CC population
- Collecting network reports from MCOs of contracted providers
- Working to engage more primary care providers
- Assessing the feasibility of regional implementation

ENGAGING PRIMARY CARE PROVIDERS

- Weekly call for CC Health Home updates
- Working with KMS, Kansas Healthcare Collaborative, KHA and KAFP on ideas to get more primary care physicians and hospitals interested
- Clinical Policy Improvement Director, Dr. Phil Bustillo, reaching out to specific practices and clinics to encourage their interest
- Continuing to work with KAMU to engage their members

FOR MORE INFORMATION

- Web page:
www.kancare.ks.gov/health_home
- Monthly newsletter: *Health Homes Herald*
- E-mail questions/comments:
healthhomes@kdheks.gov



www.kancare.ks.gov