

KanCare Health Homes Service Definitions

Comprehensive Care Management

Comprehensive care management reflects activities to promote continuity and consistency of services provided for a member, and promotes collaboration that minimizes duplication of tests, images, and service interventions. Additionally, comprehensive care management includes monitoring of prescriptions for counter-indicators related to co-occurring conditions. A person centered health action plan is established through the care coordination process. The health action plan clarifies roles and responsibilities of the MCO, the health home partner, the individual, family members and/or support providers, and the health services delivery system.

Comprehensive care management involves:

1. Identifying individuals with high risk environmental factors and/or high-risk medical factors and those with complex health care needs, who may benefit from a Health Home.
2. Conducting a comprehensive health-based needs assessment to determine the individual's physical health, mental health, chemical dependency, and social needs.
3. Developing a health action plan based on the comprehensive needs assessment, and with the input of the individual, family members or other persons who provide support, and guardians.
4. Coordinating and collaborating with other service providers.

Critical components of comprehensive care management include, but are not limited to:

- knowledge of the medical and non-medical service delivery system within the individual's area, as well as resources available outside of the individual's service area
- effective communication with the individual, family members or other persons who provide support, guardians, and service providers
- culturally, linguistically, and disability appropriate communication and services
- addressing other barriers to success, such as low income, housing status, social supports, functional abilities, including reading level and understanding of health conditions, limited or no access to transportation, etc.
- continued monitoring and follow-up to ensure that needed care and services are provided and accessed
- routine and periodic reassessment, at a minimum, every six months, and a revision of the health action plan to reflect service effectiveness in improving or maintaining health status or other circumstances or needs.

The health action plan includes the following information:

- health goals for the individual
- physical, behavioral, chemical dependency and social services that the individual needs
- who is responsible for coordinating and providing these services, i.e., MCO, Health Home partner, other service providers
- where services are offered
- advanced directives
- pertinent components of plans developed by service providers with whom the individual is involved, i.e., behavioral, long term care, etc., may be included.

Care Coordination and Health Promotion

Care Coordination

The care coordinator has an essential role in assisting an individual over time to manage a chronic condition(s) that includes: screening for other health risks, promoting healthy functioning, ensuring timely and coordinated services are obtained for acute episodes of illness or injury; as well as providing education and support in managing a chronic condition or multiple co-occurring conditions.

Care coordination is the implementation of a single, integrated health action plan (with active client involvement) through appropriate linkages, referrals, coordination, collaboration, and follow-up to needed services and supports. Care coordination should assist in the attainment of the individual's goals and improvement of chronic conditions. It should be provided timely, and address needs expressed by the individual.

Care coordination activities include, but are not limited to:

1. Assigning each enrolled individual to one dedicated care manager who is responsible for overall management of the individual's health action plan.
2. Coordinating and collaborating with other providers to monitor the individual's health status, medical conditions, medications, and side effects of medications.
3. Scheduling referrals and creating/promoting linkages to other agencies, services, and supports.
4. Assisting in the scheduling of appointments.
5. Sharing information with individuals, families, guardians, or other support persons regarding specific disorders, treatment and provider options, test results, systems of support, services and assistance available.
6. Supporting adherence to treatment recommendations, and engaging and retaining health home participants in care.
7. Monitoring ED and Inpatient admissions to ensure transitions in care are coordinated
8. Engaging patients in self-care regarding chronic conditions.
9. Palliative care, end of life decisions and supports, family engagement, pain management
10. Communicating among individuals, family members, other support persons, and guardians, and service providers during transitions of care/hospital discharges.
11. Implementing and managing the health action plan through the use of quality metrics, assessment survey results and utilization of services in order to monitor and evaluate the impact of interventions.
12. Referring for long-term services and supports.
13. Locating resources beyond the scope of services covered by Medicaid, such as those which may be available from family members, community-based organizations, service providers, grants, social programs, funding options, school-based services, faith based organizations, etc.
14. Monitoring the individual's progress toward achievement of goals on an ongoing basis.
15. Revising the health action plan as often as necessary in order to reflect the needs of the individual.

Health Promotion

Health Promotion services are designed to encourage and support healthy ideas and behavior, with the goal of motivating individuals to successfully monitor and manage their health. Health promotion services place a strong emphasis on self-direction and skills development.

Health Promotion services may include, but are not limited to, the following:

1. Actively seeking to engage patients in care by phone, letter, HIT and community “in reach” and outreach.
2. Assess individual’s motivation to engage in self-management, e.g., how important is the person’s health status to the individual; or how confident the individual feels to change health behaviors.
3. Assessing individual’s understanding of his or her health condition—health literacy.
4. Engaging person or authorized representative in making health services decisions using decision-aids or other methods that assist the individual to evaluate the risks and benefits of recommended treatment.
5. Assisting individuals in the development of recovery plans including self-management and/or relapse prevention plans.
6. Ensuring that all health action goals are included in person centered care plans.
7. Providing health education and coaching to individuals and family members about chronic conditions and ways to manage health conditions based upon the individual’s preference
8. Providing prevention education to individuals and family members about proper nutrition, health screening, and immunizations.
9. Linking individuals with resources for smoking cessation, diabetes, asthma, hypertension, self- help recovery resources, and other services based on individual needs and preferences.
10. Assisting individuals to develop the skills and confidence that will enable them to independently identify, seek out and access resources that will assist in managing and mitigating their conditions, and in preventing the development of secondary or other chronic conditions.

Comprehensive Transitional Care

Comprehensive Transitional Care services are specialized care coordination designed to facilitate continuity through coordination of treatment plans between hospitals, including emergency department and inpatient units; long-term service providers; rehabilitation facilities; and other health services systems. An important feature is timely follow-up when an individual is moving from one level of service provision, e.g., hospital to a community-based program. An important goal of comprehensive transitional services is to streamline plans of care, reduce avoidable hospital admissions/readmissions, and reduce emergency department utilization. It is also designed to ease the transition to other long term services and supports, addressing the individual’s understanding of what rehabilitation activities and medications are needed to be continued or discontinued and when a next medical appointment is scheduled and interrupt patterns of frequent hospital emergency department use. For each health home enrollee transferred from one caregiver or site of care to another, the health home ensures proper and timely follow-up care and safe, coordinated transitions, including reconciliation of medications.

Comprehensive transitional care services include, but are not limited to:

1. Establishing collaborative relationships, communicating and coordinating with individuals, families, guardians and other support persons, hospital emergency departments, long term care settings, physicians, nurses, social workers, discharge planners, and service providers.
2. Developing a transition plan with the individual, family or other support persons, or guardians, as well as other providers, and transmitting a comprehensive transition/discharge plan to all involved. The transition/discharge plan includes but is not limited to the following elements:
 - a. timeframes related to appointments and discharge paperwork
 - b. follow-up appointment information
 - c. medication information to allow providers to reconcile medications and make informed decisions about care
 - d. medication education
 - e. therapy needs, e.g., occupational, physical, speech, etc.
 - f. transportation needs
 - g. community supports needed post-discharge
 - h. determination of environmental (home, community, workplace) safety.
3. Assuring proper and timely access to follow-up care.
4. Monitoring follow-up appointments and reaching out to the individual if an appointment is missed.
5. Educating regarding self-management
6. Evaluating the need to revise the health action plan.
7. Comprehensive transitional care may also involve identifying individuals not participating who could benefit from a Health Home.

Individual and Family Support

Individual and family support is defined as identifying services that the individual, family or other support persons, and guardians may need to manage their conditions, assisting them to access these services, with the ultimate goal of improved overall health and quality of life. The provision of individual and family support is contingent on effective communication with the individual, family, guardian, other support persons, or caregivers. It involves accommodations related to culture, disability, language, race, socio-economic background, and non-traditional family relationships. It also involves the ability to determine when patients and families are ready to receive and act upon information provided, and assisting them when making informed choices. It may involve an awareness of the complexities of family dynamics, and an ability to respond to meet the individual's needs when complex relationships come into play. In order to promote inclusion, consideration should be given to accommodating work schedules of families, teleconferencing, and provider flexibility in terms of hours of service.

Individual, family, or other support persons, and guardian support may include, but are not limited to, any or all of the following:

1. Assessing the strengths and needs of individuals, family or other support persons, and guardian.
2. Identifying resources that will help individuals, family or other support persons, and guardians to reduce barriers to their highest level of health and success.
3. Advocating on behalf of individuals, family or other support persons, and guardian, to ensure that they have the services and supports necessary for improved health.
4. Promoting the engagement of individuals, family or other support persons, and guardians.
5. Promoting the self-management capabilities of individuals.

6. Increasing the individual's, family' or other support persons', and guardians', understanding of the effect(s) of the condition on the individual and the individual's life.
7. Assisting individuals to improve their adherence to an agreed upon treatment plan.
8. Assisting to complete paperwork necessary to access services.
9. Providing information and assistance in accessing needed self-help and peer support services.
10. Considering the family's and support persons', or guardians' need for services such as respite care.

Referral to Community and Social Support Service

This service involves identifying available resources in the community, assisting the individual in advocating for access to care, and engagement with community and social supports. Community and social support services include long-term services and supports, mental health, substance use disorder and other community and social services accessed by the individual.

Referral to community and social support services includes, but are not limited to, the following:

1. Determining the services needed for the individual to achieve the most successful outcome.
2. A thorough knowledge of the medical and non-medical service delivery system within and outside of the individual's area.
3. Knowledge of the eligibility criteria for services.
4. Considering the individual's, family's, guardian', or other supports person's preferences, when possible.
5. Assisting in the completion of paper work.
6. Following through until the individual has access to needed services
7. Fostering communication and collaborating with social supports.
8. Establishing and maintaining relationships with community services providers, e.g., Home and Community Based Services (HCBS) providers, the Aging & Disability Resource Center (ADRC), faith-based organizations, etc.
9. Identifying natural supports if services providers are unavailable in the individual's community.
10. Identifying sources for comprehensive resource guides, or develop a comprehensive resource guide if necessary.

Use of HIT to Link Services

Health information technology is used to facilitate sharing of information between and among health service professionals, monitoring service utilization, and supporting an individual in self-management of his or her health condition.

Activities may include, but are not limited to:

- Developing registries to monitor evidenced treatment activities.
- Developing referral tracking systems to monitor specialty services utilization.
- Developing notification systems to identify individual's admission or discharge from an emergency department, inpatient, or residential/rehabilitation setting.
- Monitoring prescriptions for counter-indicated prescriptions and refills of needed medications.

- Mobile technologies for self-monitoring with provider notification systems.
- Directing provider communications (continuity of care documents).

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