

HEALTH HOMES SERVICE DEFINITIONS



INTRODUCTION

- The Affordable Care Act lists six core services
- States must define each service within their State Plan Amendment (SPA) for health homes conditions
- Additionally, States must describe how HIT will be used to link services

SIX CORE SERVICES

- Comprehensive care management
- Care Coordination and health promotion
- Comprehensive transitional care
- Individual and family supports
- Referral to community and social supports
- Use of HIT to link services

OUR PROCESS

- Reviewed other states' SPAs
- Gathered initial thoughts from Focus Group
- Prepared draft definitions
- Gathered reactions from: Project Team, Focus Group, April Forum participants



OUR PROCESS

- Worked with sub-group
- Reviewed subsequent SPAs
- Got input from our technical assistance partner (Center for Health Care Strategies)
- Consult with SAMHSA
- Share with CMS





TWO SPAS

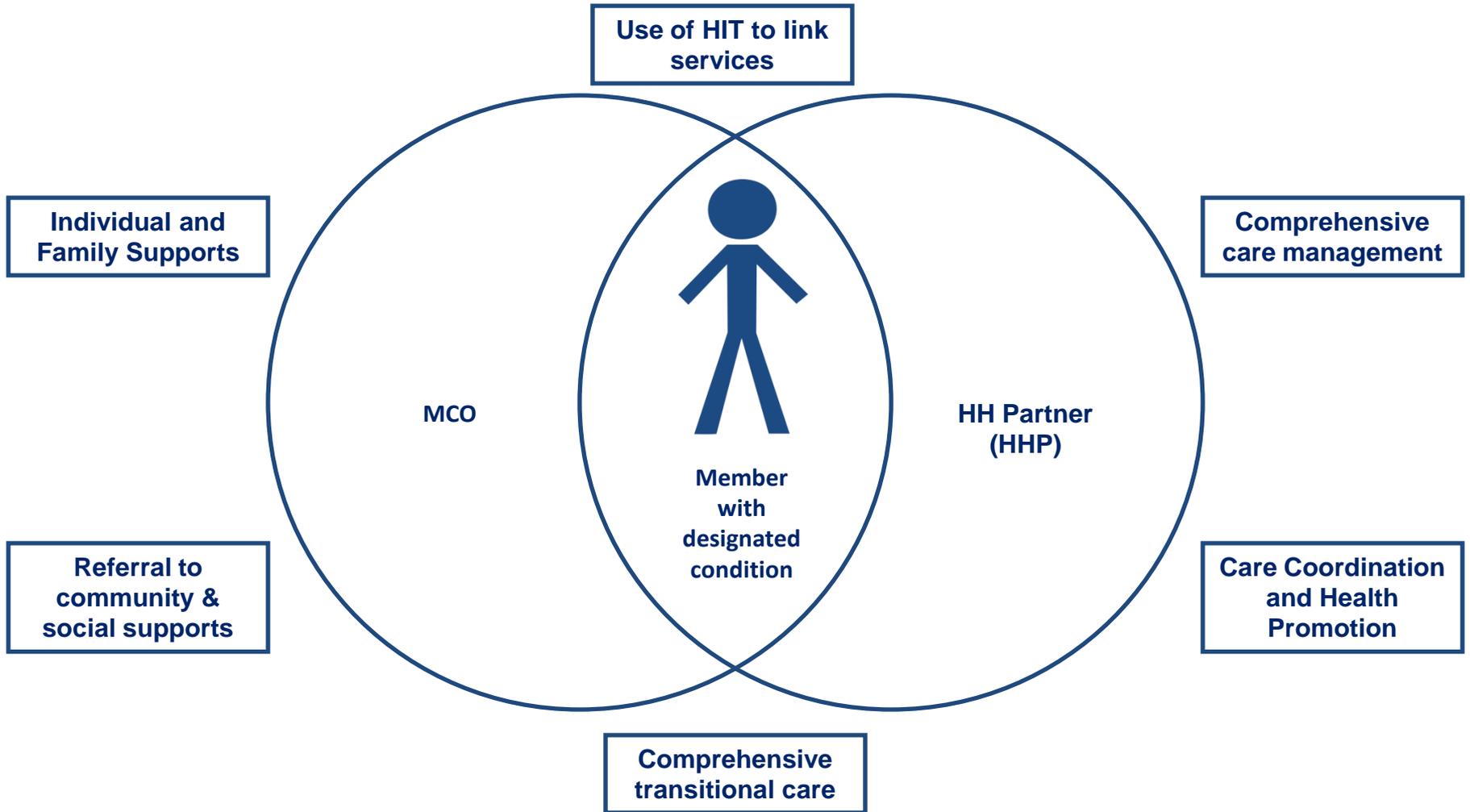
- HHS Sub-cabinet, led by Lt. Governor, approved submitting two SPAs
- Developed service definitions as though for a single SPA
- Tried to incorporate components of targeted case management (TCM)

WHO PROVIDES THE SERVICES?

- KanCare Health Homes will be provided jointly by MCO (Lead Entity) and community provider (Health Home Partner)
- Services defined without regard to who provides them



SERVICE STRUCTURE



DRAFT DEFINITIONS

For complete draft definitions, refer to June 28, 2013 document posted at:

http://www.kancare.ks.gov/health_home.htm

COMPREHENSIVE CARE MANAGEMENT

- Identifying individuals who may benefit from a Health Home.
- Conducting a comprehensive health-based needs assessment
- Developing a health action plan
- Coordinating and collaborating with other service providers



COMPREHENSIVE CARE MANAGEMENT

- Knowledge of the medical and non-medical service delivery system
- Effective communication with everyone
- Culturally, linguistically, and disability appropriate communication and services
- Addressing other barriers to success
- Continued monitoring and follow-up
- Routine and periodic reassessment, at a minimum, every six months

COMPREHENSIVE CARE MANAGEMENT

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
- Where services are offered
- Advanced directives
- Pertinent components of plans developed by service providers with whom the individual is involved

CARE COORDINATION AND HEALTH PROMOTION

- CMS expects these to be defined separately
- *Care coordination* is the implementation of a single, integrated health action plan
- *Health promotion* services designed to encourage and support healthy ideas and behavior, with the goal of motivating individuals to successfully monitor and manage their health



CARE COORDINATION

- Care coordinator has an essential role in assisting an individual over time to manage a chronic condition(s)
- Should assist in the attainment of the individual's goals and improvement of chronic conditions
- Should be provided timely, and address needs expressed by the individual



HEALTH PROMOTION

- Services 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



COMPREHENSIVE TRANSITIONAL CARE

- Specialized care coordination designed to facilitate continuity through coordination of treatment plans between hospitals, long-term service providers, rehabilitation facilities, etc.
- Timely follow-up when individual moving from one level of service provision to another
- Ensures proper and timely follow-up care and safe, coordinated transitions, including reconciliation of medications



INDIVIDUAL AND FAMILY SUPPORT

- Identifying services needed to manage their conditions, assisting to access these services, with the ultimate goal of improved overall health and quality of life
- Contingent on effective communication with the individual, family, guardian, other support persons, or caregivers
- Involves accommodations related to culture, disability, language, race, socio-economic background, and non-traditional family relationships

INDIVIDUAL AND FAMILY SUPPORT

- Involves ability to determine when individuals and families are ready to receive and act upon information provided, and assisting them when making informed choices
- 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

REFERRAL TO COMMUNITY AND SOCIAL SUPPORT SERVICES

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

- Identifying available resources in the community
- Assisting the individual in advocating for access to care
- Engagement with community and social supports

USE OF HIT TO LINK SERVICES

- 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

USE OF HIT TO LINK SERVICES

- 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)



LINKING HIT TO SERVICES

CMS expects the State to explain, for each core service, how HIT will be used to link the service “in a comprehensive approach across the care continuum.”



NEXT STEPS - STATE

- Incorporate feedback from the Forum in development of the SPA
- Add ways HIT can link each service
- Submit SPA to CMS
- Target date for HH implementation is January 1, 2014



NEXT STEPS - STAKEHOLDERS

- Learn more about Health Homes development – check updates on the KanCare website
- Reach out to MCOs if interested in being a HH partner
- Analyze your agency's readiness to a HH partner



QUESTIONS?

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Kansas Department of Health and
Environment

http://www.kancare.ks.gov/health_home.htm



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