



WICHITA STATE
UNIVERSITY

Health Homes Webinar Series: Health Action Plan: Step by Step

Mary Ellen O'Brien Wright

KDHE Division of Health Care
Finance

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Welcome!

- The Health Home Webinar Series is presented to highlight tools and resources available to potential Health Home Partners
- Posted on the KanCare website for future reference
- Thank you for calling in! All caller phones are muted for the duration of the presentation.
- Enter questions via “Question” box on your screen



Purposes for Today

- Increase participant understanding of who is involved and how to complete the Health Homes Health Action Plan
- Allow participants to ask staff from KDHE and MCOs questions of clarification regarding the Health Action Plan



KanCare Website

KanCare
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Latest News – Upcoming Events
Meetings for Members with Serious Health Conditions
I/DD Waiver Services' Incorporation into KanCare
Open Enrollment for Members with Jan. 1 Anniversary
Important message for Members (Video)

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Sect. 1115 Waiver and Comments
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Medicaid for Kansas

Health Homes in KanCare

Consumers

Providers

FAQs

News and Events

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KanCare Website



Medicaid for Kansas

Health Home in KanCare

Providers

Informational Materials for Providers:

Health Home	
Provider Regional Meetings	
Approaches to Health Homes	
Payment Principles and Parameters:	
Services	
Informational Materials for Providers:	
Stakeholder Meetings	
Health Homes Webinar Series	
Contacts	

Serious Mental Illness (SMI)

- SMI State Plan Amendment
- KanCare Health Homes Program Manual – SMI
- SMI Health Homes Provider Requirements
- SMI Health Homes Services and Professional Requirements
- Target Population Estimates

Chronic Conditions (CC)

- CC State Plan Amendment
- CC Health Homes Provider Requirements
- CC Health Homes Services and Professional Requirements
- Kansas CC Health Homes Target Population
- Target Population Estimates (.xlsx)

Health Action Plan

- Health Action Plan Instructions
- Health Action Plan

Health Action Plan Basics

Introduction

- Health Action Plan is a tool to document
 - Member's Health Home goals
 - strategies to achieve goals
 - progress towards achieving goals
 - Member and providers specific responsibilities related to Health Home goals
- Required for every Member enrolled in Health Homes
- Developed by the Member with the assistance of the Health Home Care Coordinator in a face-to-face meeting following the initial assessment of the Member's health
- Includes input from other Health Home team members and anyone the Member chooses to involve

Introduction

- Updated at least quarterly
 - Should reflect status toward achieving goals, current needs, service effectiveness in improving or maintaining health status, and other circumstances
- Not intended to replace specific treatment plans or person centered support plans that are already required.
- Not intended to be the clinical record.
- Designed to capture critical information that can be shared with all providers involved with the Member.

Introduction

The Health Action Plan (HAP) includes:

- Demographic information
- Contact information
- Physical and behavioral health information
- Home & Community Based Services (HCBS) waiver information (if applicable)
- Advanced Directive information (if applicable)
- Health Home goals, steps to achieve each goal, strengths/needs, measurable outcomes, and progress
- Signatures

Role of the Care Coordinator

Provides overall coordination of the Member's HAP, including:

- Assisting to determine services needed
- Locating needed services
- Ensuring that Member can access services (transportation, comprehension, etc.)
- Referring
- Scheduling appointments
- Following-up

Role of the Care Coordinator

- Sharing information with all involved parties,
- Monitoring Emergency Department (ED) and inpatient admissions to ensure coordinated care transitions
- Documenting progress toward achieving goals in the Health Action Plan

Health Action Plan: Step by Step

Health Action Plan Form

SECTION I. Demographic Information	
Member Name: <input type="text"/>	KanCare ID No.: <input type="text"/>
Address: <input type="text"/>	
Phone: <input type="text"/>	Date of Birth: <input type="text"/> Gender: <input type="text" value="Select"/>
Primary Language: <input type="text"/>	Race: <input type="text" value="Select"/>
SECTION II. Additional Contact Information	
Parent/Foster Parent/Legal Guardian: <input type="text"/>	
Address: <input type="text"/>	Phone: <input type="text"/>
Medical Power of Attorney: <input type="text"/>	
Address: <input type="text"/>	Phone: <input type="text"/>
KanCare MCO: <input type="text"/>	
MCO Care Manager: <input type="text"/>	
Address: <input type="text"/>	Phone: <input type="text"/>
Health Home Partner: <input type="text"/>	
Health Home Care Coordinator: <input type="text"/>	
Address: <input type="text"/>	Phone: <input type="text"/>
Other Support Person: <input type="text"/>	
Address: <input type="text"/>	Phone: <input type="text"/>

Health Action Plan Form

SECTION III. Physical and Behavioral Health			
Provider: <input type="text"/>			
Address: <input type="text"/>		Phone: <input type="text"/>	
Kan Be Healthy Screen: <input type="text"/> (Children only) Date: <input type="text"/>			
Health Risk Assessment: <input type="text"/> Date: <input type="text"/>			
Physical Health:			
Physical Health Diagnoses: <input type="text"/>			
Height: <input type="text"/>		Weight: <input type="text"/> Date: <input type="text"/>	
Cardio: BP: <input type="text"/> Date: <input type="text"/>		Diabetes: A1c: <input type="text"/> Date: <input type="text"/>	
Obesity: BMI: <input type="text"/> Date: <input type="text"/>		LDL-c: <input type="text"/> Date: <input type="text"/>	
Tobacco use: <input type="text"/> Describe current usage if yes: <input type="text"/>			
Behavioral Health:			
Mental Health Diagnoses: <input type="text"/>			
Depressions Screening performed: <input type="text"/> Date: <input type="text"/>			
Substance Use Disorder Brief Screen: <input type="text"/> Date: <input type="text"/>			
Substance Use Disorder Assessment: <input type="text"/> Referral: <input type="text"/> Date: <input type="text"/>			
Results of Screening: <input type="text"/>			
Drug(s) of Choice: <input type="text"/>			
Medication/Reconciliation:			
Medication Name	Dosage and Frequency	Prescribed By	Additional Information about Medications
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Health Action Plan Form

SECTION IV. Existing HCBS Waiver Plan of Care (If applicable)	
Do you have an existing HCBS Waiver Plan of Care? <input type="text" value="Select"/>	
Plan type: <input type="text" value="Select"/>	
SECTION V. Advanced Directives	
Advanced Directives: <input type="text" value="Select"/>	
SECTION VI. Goals and Steps to Achieve (Goals must address needs and must have measurable outcome)	
Goal: <input type="text"/>	
Steps to Achieve Goal: <input type="text"/>	
Strength and Needs: <input type="text"/>	
Measurable Outcome: <input type="text"/>	
Start Date: <input type="text"/>	Completion Date: <input type="text"/>
Progress (date): <input type="text"/>	
Goal: <input type="text"/>	
Steps to Achieve Goal: <input type="text"/>	
Strength and Needs: <input type="text"/>	
Measurable Outcome: <input type="text"/>	
Start Date: <input type="text"/>	Completion Date: <input type="text"/>
Progress (date): <input type="text"/>	

HAP Section VI – Goals & Steps to Achieve



Goal:

Activity that will contribute to improving the Member's health and well being.

Example:

“Earleen will have a Primary Care Physician (PCP) to oversee her medical care.”

HAP Section VI – Goals & Steps to Achieve

Steps to Achieve Goal:

Steps that will be taken to achieve the goal, including who is responsible and where services will be provided.



Example:

“Earleen’s Care Coordinator will:

- Assist her to choose a PCP and help her schedule her first appointment
- Attend Earleen’s first appt. to help her understand the information provided by her PCP
- Educate Earleen regarding how to set up transportation through her MCO for future appointments
- Follow-up with Earleen after each of her visits to ensure that she understands of information”

HAP Section VI – Goals & Steps to Achieve



Measurable Outcomes:

How will it be determined that this goal was met?

Example:

“Earleen will select a PCP, schedule and attend an initial appointment.

She will continue to see her PCP on a schedule recommended by her PCP.”

HAP Section VI – Goals & Steps to Achieve

Progress:

Document any progress toward meeting the goal.

Example:

“Earleen selected a PCP from a list provided by her Care Coordinator. With the assistance of her Care Coordinator, she scheduled her first appointment for 2/11/14 at 1:30 p.m. Her Care Coordinator took her to her initial appointment. She is scheduled to see her PCP quarterly, and knows how to arrange transportation through her MCO.”



Health Action Plan Form

SECTION VII. Signatures		
Completed by:	Select	Date:
Completed by:	Other: Describe Other:	Date:

Questions?

Contact Information

Samantha Ferencik – KDHE

sferencik@kdheks.gov

Leslie Banning – Amerigroup

KSHealthHome@amerigroup.com

Dorothy Keller – Sunflower State Health Plan

LEN_SFSHPHOMEHEALTH@centene.com

Ben Pierce – United Healthcare

uhckshealthhomes@uhc.com

Save the Dates! *(All sessions 12-1 p.m.)*



- Apr 29 – Health Information Technology Basics
- May 20 – Health Home Core Services
- May 27 – Health Promotion
- June 17 – Targeted Case Management (I/DD)
- June 24 – Health Care Providers

**Thank you for
participating!**