



WICHITA STATE
UNIVERSITY

Health Homes Webinar Series: Health Information Technology (HIT) Basics

Becky Ross

KDHE Division of Health Care
Finance

April 29, 2014

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 the basic Health Information Technology (HIT) expectations & requirements for the Health Homes initiative
- Share HIT resources that are currently available
- Provide opportunities to ask questions of staff from KDHE and MCOs



KanCare Website

KanCare
AD ASTRA PER ASPERA

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)

About Us News Workgroups/Council I/DD Health Plans Contact Us

Medicaid for Kansas

KanCare Consumer Assistance: 1-866-305-5147

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Benefits & Services
Apply for Medicaid/KanCare
Choosing a KanCare Health Plan
Events
Frequently Asked Questions
...More

Providers
Become a KanCare Provider
Frequently Asked Questions
Events
KanCare Health Plan Information
Pharmacy
Provider Billing Information

Policies & Reports
Medical Assistance Reports
KanCare Quality Measurement
Health Homes in KanCare
Readiness Activities
Delivery System Reform Incentive
Annual and Quarterly Reports

About Us
What is KanCare?
Kansas Medicaid Reform
Sect. 1115 Waiver and Comments
News
Advisory Council & Workgroups
Frequently Asked Questions

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Medicaid for Kansas

Health Homes in KanCare

Consumers

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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 Information Technology Requirements

Introduction

Implementation of an Electronic Health Record (EHR) will be required of all Lead Entities and Health Home Partners to facilitate the sharing of patient information across health settings.



Health Home Partner Requirements

Health Homes Partners must commit to the use of an interoperable EHR through the following:

- Submission of a plan to the Lead Entity, within 90 days of contracting as a HHP, to implement the EHR;
- Full implementation of the EHR within a timeframe approved by the Lead Entity; and
- Connection to one of the two certified state Health Information Exchanges within a timeframe approved by the Lead Entity:
 - Kansas Health Information Network (KHIN) or
 - Lewis And Clark Information Exchange (LACIE).

Joint Lead Entity & HHP Requirements

Lead Entities (MCOs) and Health Home Partners must both:

- Demonstrate a capacity to use health information technology to link services;
- Facilitate communication among team members and between the health team and individual and family caregivers;
- Provide feedback to practices, as feasible and appropriate; and
- Demonstrate the ability to report required data for both State and Federal monitoring of the program.

Requirements for the Six Core Services

Comprehensive Care Management:

- Details of the health action plan will be documented in the EHR to facilitate the sharing of patient needs across health home providers.
- The use of HIT via established networks will ensure that providers are updated on changes to patients' health action plans and care requirements.
- HIT will allow for the continuous monitoring of patient outcomes and the appropriate changes in care and follow up.

Requirements for the Six Core Services

Care Coordination:

- Lead Entities and HHPs use of KHIN and/or LACIE will allow for documentation, execution, continuous monitoring, and updates to the health care plan that will impact patient outcomes, treatment options, and follow-up.
- Until HHPs and Lead Entities are fully connected to HIEs, Lead Entities must provide a bi-directional electronic method for viewing and sharing data with the HHP.

Requirements for the Six Core Services

Health Promotion:

- Lead Entities and HHPs will use secure emails, member web portals and smart phone applications to promote, manage, link, and follow-up on health promotion activities including patient engagement, health literacy, and recovery plans.

Requirements for the Six Core Services

Comprehensive Transitional Planning:

- Electronic and telephonic 24x7 notifications of hospitalizations to the Lead Entities will be shared through secured email or other secure electronic means with HHPs. HHPs will use secure portals of Lead Entities websites to assist in developing transition plans.

Requirements for the Six Core Services

Individual and Family Support:

- Lead Entities will modify existing member portals that will be used as a communication tool to encourage individual and family support services.
- The portal will be available to members and will outline information relating to medical and behavioral conditions, evidence based treatment options, and links to local and national support resources.
- HHPs will use their existing websites and secure email to share information with members.

Requirements for the Six Core Services

Referral to Community and Social Supports:

- The Health Home member portal, managed by the Lead Entities and accessible to members, will include information and links to community and social support resources.
- HHPs will use their existing websites and secure email to share information with members.

Documentation Requirements

Health Home Documentation Requirements



Each Lead Entity will have some specific requirements, spelled out in their contracts with HHPs.

However, all three MCOs have agreed to basic documentation requirements that are designed to demonstrate HHPs have provided specific core Health Home services.

Health Home Documentation Requirements

Comprehensive Care Management:

Documentation:

- Health Action Plan (HAP) in the patient record;
- Notes in the patient record with date and time (including duration),
- Discussion points with the member or other practitioners,
- Indication that the Plan was shared with all other treating practitioners and others involved in providing or supporting care.

Examples of HIT:

Data or reports used:

- to identify participants assigned to the Health Home by the MCO,
- to develop or recommend the Health Action Plan;
- to provide evidence of sharing the HAP with the participant, other practitioners or the MCO via electronic means.

Health Home Documentation Requirements

Care Coordination:

Documentation:

- Patient record entries with date, time, practitioner providing the service, referral, follow-up or coordination activity with the member, treating practitioners and others involved in providing or supporting care.
- Patient record note could denote an ER visit, hospital admission, phoning member with lab results, discussing a consult with another treating practitioner, etc.

Examples of HIT:

- System entries including patient notes;
- distribution of the HAP or other notes to the MCO;
- sharing of lab or other results;
- retrieving information from the MCO to track hospital, ER, and other utilization.

Health Home Documentation Requirements

Health Promotion:

Documentation:

Activities to engage member in care, including:

- outreach,
- assessment of member's health literacy,
- summary of health education and resources provided.

Examples of HIT:

Evidence of the use of data pulled from the system:

- to identify participant health promotion needs;
- notes of health promotion interactions;
- resources to which the participant is directed to address educational and health literacy needs

Health Home Documentation Requirements

Comprehensive Transitional Care:

Documentation:

- Medication reconciliation and other key treatments or services with other health systems/places of service.
- Should include: date, time, practitioner from the HHP and what specific elements of the HAP, or the Plan itself, were shared and with what other health system or place of service and to achieve which specific HAP goal.
- Attention to the appropriate providers to address the follow-up care is extremely important; e.g. transmission of the HAP to a physical therapist who will be treating a member post knee replacement.

Examples of HIT:

Use of the system to:

- identify admissions/discharge needs,
- to update the HAP based on revised needs,
- to document the scheduling and notification to participants of follow-up appointments.

Health Home Documentation Requirements

Individual and Family Support:

Documentation:

- Assessment of psychosocial or community support needs including the identified gaps and recommended resources or resolutions to address the gaps.
- Date, time, practitioner, service recommendations and discussion with the member, family (or other support persons), and/or guardian.

Examples of HIT:

Use of the system to:

- share assessment of community support or psychosocial assessments;
- update of the HAP, as applicable, to address same;
- patient record entries;
- collaboration with other practitioners as to resource information provided or recommended.

Health Home Documentation Requirements

Referral to Community and Social Support Services:

Documentation:

- Date, time and contact at a referral source and/or the date and time that a referral follow through or discussion was convened to address the gaps from the Individual and Family Support assessment process.

Examples of HIT:

Use of the system to:

- share assessment of community support or psychosocial assessments;
- update of the HAP, as applicable, to address same;
- patient record entries;
- collaboration with other practitioners as to resource information provided or recommended.

Managed Care Organization Data Portals



Leslie Banning
Health Homes Manager
KSHealthHome@amerigroup.com



Enhancing Health Home Partner Health Information Technology (HIT) Capacity

- ❑ Provider education and training- implementing health information systems
- ❑ Promote access to Amerigroup Provider Portal (best practices, screenings and assessment tools)
- ❑ Deployment of Patient 360 to support providers without the resources to engage with a Kansas health information exchange.
- ❑ HHP access Patient 360
 - Comprehensive medical service history—inpatient admissions, test and procedures, pharmacy, outpatient specialty providers
 - Health Service Plan

Patient 360

George >

Currently Enrolled ● Alerts Exist ● No OHI ●

Provider: QA
WELLPOINT

- Member Care Summary
- Claims
- Utilization
- Care Management
- Episodic Viewer
- Lab Reports

Date Range: Mar 12, 2012 to Sep 12, 2014

Update

Source	Description	Type
HEDIS	Diabetes- HbA1c Testing - Pending	Alert
HEDIS	Diabetes- LDL Screening - Pending	Alert
HEDIS	Diabetes- HbA1c > 9 - Pending	Alert
HEDIS	Diabetes- HbA1c between 8-9 - Pend...	Alert
HEDIS	Diabetes- LDL < 100 - Pending	Alert
HEDIS	Diabetes- Medical Attention for Neph...	Alert

Immunizations & Preventive Health		
Date	Service	Provider
07/19/2013	Pneumococcal polysacchari...	Jersey City Medical Ctr

Lab Results			
Date	Type	Value	Acuity
07/05/2013 12:33	Hemoglobin A1C	6	No lab acuity p...
07/05/2013 12:33	LDL	157	No lab acuity p...
07/05/2013 12:33	HDL	65	No lab acuity p...
07/05/2013 12:33	Total Cholesterol	241	No lab acuity p...
07/05/2013 12:33	Blood creatinine	0.7	No lab acuity p...
05/21/2013 00:00	T4, FREE	1.3	Normal
05/21/2013 00:00	PROTEIN, TOTAL	6.2	Normal

Inpatient			
Admit Date	Discharge Date	Facility Name	Primary Diag
08/07/2013	08/12/2013	Jersey City Medical Ctr	Chronic airway obstruct...
08/07/2013	08/08/2013	Jersey City Medical Ctr	Chronic airway obstruct...
07/19/2013	07/24/2013	Jersey City Medical Ctr	Chronic bronchitis with...
06/08/2013	06/10/2013	Jersey City Medical Ctr	Other dyspnea and res...
06/08/2013	06/10/2013	Jersey City Medical Ctr	Chronic obstructive ast...
04/29/2013	05/01/2013	Jersey City Medical Ctr	Obstructive chronic bro...
02/19/2013	02/21/2013	Jersey City Medical Ctr	Chronic airway obstruct...

Emergency Department			
Date	Facility Name	Primary Diagnosis	
06/08/2013	Liberty Emergency Medical As...	Other dyspnea and respirator...	
04/29/2013	Liberty Emergency Medical As...	Obstructive chronic bronchitis...	
02/19/2013	Liberty Emergency Medical As...	Chronic airway obstruction, n...	

Pharmacy		
Date	Medication/Strength	Prescriber
01/01/2014	FOLIC ACID TAB 1MG	Elamir, Mazhar
12/30/2013	METOCLOPRAM TAB 10MG	Elamir, Mazhar
12/30/2013	LACTULOSE SOL 10GM/15	Salah-eldin, Alaa
12/30/2013	ALFUZOSIN HCL ER 10 MG...	Elamir, Mazhar
12/30/2013	MINTOX SUS	Elamir, Mazhar
12/30/2013	OMEPRAZOLE CAP 20MG	Elamir, Mazhar
12/30/2013	IPRATROPIUM SOL 0.02%I...	Elamir, Mazhar

Authorizations						
Auth Number	Start Date	End Date	Place of Service	Referred To Provider	Status	
C01228606	08/07/2013	08/12/2013	Inpatient Hospital	Jersey City Medical Ctr	Discharged	
C01228191	08/07/2013	08/08/2013	Inpatient Hospital	Jersey City Medical Ctr	Void	
103658934	07/19/2013	01/18/2014	Outpatient Hospital	Senior Spirit Of Jersey City Adult Medic...	Complete	
C01191978	07/19/2013	07/24/2013	Inpatient Hospital	Jersey City Medical Ctr	Discharged	
103647282	07/16/2013	07/16/2013	Patient's Home	Loving Care Agency	Complete	
103629058	07/03/2013	08/03/2013	Ambulance-Land	Ostrich Medical Transportation	Complete	
C01110310	06/08/2013	06/10/2013	Inpatient Hospital	Jersey City Medical Ctr	Disallowed	

Office Visits		
Date	Provider	Primary Diagnosis
07/15/2013	Raginsky, Boris	Other peripheral vascular...
07/03/2013	Elamir, Mazhar E	Shortness of breath
06/19/2013	Elamir, Mazhar E	Essential hypertension, be...
06/14/2013	Salah-eldin, Alaa A	Acute gastritis without men...
05/20/2013	Lala, Vinod R	Diabetes mellitus without...
04/26/2013	Fatah, Nail A	Asthma, unspecified with st...
04/17/2013	Elamir, Mazhar E	Cough

Home Mods and Equipment Claims		
Date	Provider	Service

Other Claims		
Date	Provider	Service
08/08/2013	Quality Home Care Providers	O2 conc 1 del port 85%>0...
07/30/2013	Senior Spirit Of Jersey City	Day Care Services Adult P...

Local intranet | Protected Mode: Off

100%



Promote HHP Access of Amerigroup Member Portal

Health Promotion and Health Education

- Online connections to peer supports
- Nutrition guides
- Personal health record
- A to Z health information
 - ✓ Tips to address health issues
 - ✓ Shared decision-making

[En Español](#)

Make better health decisions



Health tool picture

[Interactive Tools >](#)



[Health Topics >](#)



[Learning Centers >](#)

Check Your Symptoms

Find out what to do

[Start Now](#)



Browse health information

Healthwise® Knowledgebase



Topics A-Z

[A](#) [B](#) [C](#) [D](#) [E](#) [F](#) [G](#) [H](#) [I](#) [J](#) [K](#) [L](#) [M](#) [N](#) [O](#) [P](#) [Q](#) [R](#) [S](#) [T](#) [U](#) [V](#) [W](#) [X](#) [Y](#) [Z](#) [\(0-9\)](#)

When you need to decide



Decision tools about:

[Surgeries](#)

[Medical Tests](#)

Sunflower Health Plan

Health Home Program

Provider Portal



SunFlower State Health | Currently sharing | Give Control | Stop Sharing

https://support.sunflowerstatehealth.com/careconnect/memberDetails?displayMedicaidId=

File Edit View Favorites Tools Help

SunFlower State Health Provider Tools

Coordination of Benefits

Claims

Age [Redacted] Phone Number [Redacted]

Member # [Redacted]

Address [Redacted]

Eligibility History

Start Date	End Date	Product Name
Mar 1, 2014	Dec 31, 9999	TANF
Aug 1, 2013	Feb 28, 2014	TANF

[more](#)

[View PCP History](#)

Name	Start Date	End Date
[Redacted]	Mar 1, 2014	Dec 31, 9999
[Redacted]	Aug 1, 2013	Feb 28, 2014
[Redacted]	Apr 13, 2013	Jul 31, 2013
[Redacted]	Apr 1, 2013	Apr 12, 2013

[Care Gaps](#)

Due for blood lead test on or before 2nd birthday

[Allergies](#)

None On File

[View Clinical Information](#)

Error on page. | Internet | Protected Mode: Off | 100%



SunFlower State Health | Currently sharing | Give Control | Stop Sharing

https://support.sunflowerstatehealth.com/careconnect/memberDetails?displayMedicaidId=...

SunFlower State Health Provider Tools

[View Clinical Information](#)

Three Most Recent ER Visits

Primary Diagnosis	Date	Facility/Provider
DIAPER OR NAPKIN RASH	09/16/2013	THE UNIVERSITY OF KANSAS HOSPITAL
FEVER NOS	08/28/2013	THE CHILDRENS MERCY HOSPITAL MO
FEVER NOS	07/28/2013	THE CHILDRENS MERCY HOSPITAL MO

Top 5 Most Occurring Diagnosis

- ROUTINE INFANT/CHILD HEALTH CHECK
- FEVER NOS
- OTH SPEC CONDS ORIG PERINTL PERIOD
- SINGLE LIVEBORN HOSP W/O C-SEC
- NB FEEDING PROBLEMS

Recent Pharmacy Activity

- FLUCONAZOLE SUS 10MG/ML
- MAPAP LIQ 160/5ML
- MUPIROCIN OIN 2%

Three Most Recent Inpatient Admissions

None On File

Three Most Recent Office Visits

Primary Diagnosis	Date	Facility/Provider
ROUTINE INFANT/CHILD HEALTH CHECK	01/16/2014	[REDACTED]
ROUTINE	01/16/2014	[REDACTED]

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Provider Portal



Overview

Cost Sharing

Assessments

Health Record

Care Plan

Authorizations

Coordination of Benefits

Claims

Visits Medications Immunizations Labs Allergies

Fill Date	Drug Name	Dose	Quantity	Dispensing Pharmacy
10/08/2013	FLUCONAZOLE SUS 10MG/ML	10 MG/ML	35	CHILDRENS MERCY WEST PHARMACY/THE CORDEL
10/08/2013	MAPAP LIQ 160/5ML	160 MG/5ML	118	CHILDRENS MERCY WEST PHARMACY/THE CORDEL
10/08/2013	MUPIROCIN OIN 2%	2 %	22	CHILDRENS MERCY WEST PHARMACY/THE CORDEL
09/17/2013	NYSTATIN CRE 100000	100000 UNIT/GM	30	WALGREENS #7550
09/17/2013	NYSTATIN SUS 100000	100000 UNIT/ML	60	WALGREENS #7550
06/10/2013	DEEP SEA SPR 0.65%	0 %	44	CHILDRENS MERCY WEST PHARMACY/THE CORDEL
06/10/2013	MAPAP LIQ 160/5ML	160 MG/5ML	118	CHILDRENS MERCY WEST PHARMACY/THE CORDEL
05/03/2013	SIMETHICONE DRO 40/0.6ML	40 MG/0.6ML	30	CHILDRENS MERCY WEST PHARMACY/THE CORDEL

Done

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United Healthcare – Community Care

April 2014

Main Dashboard



Home

Health Home Dashboard Apps

 Admin	 Enrollment	 Care Teams	 Reports	 Care Plan	 Messages	 Alerts
--	---	--	---	--	---	---

Access to applications is controlled by user level.

Building the Care Team

Modify Care Team ✕

Care Team Name :

Psychiatrist ▼

Select Providers

Prefix	First Name	Last Name	Credential	User Level	Organization

No records found. Page 1 of 1 Page size : 10 ▼

Selected Providers

Prefix	First Name	Last Name	Credential	User Level	Organization
	Kathleen	Herriges	RN	Care Manager	UHC Service B...
	Christine	Young	RN	Medical Care ...	Agency on Ag...
	Mary	Noyes	ADMIN	Social Servic...	Agency on Ag...
	Sandra	Phillips	ADMIN	Social Servic...	Agency on Ag...
	Michael	Thomas	MD	Psychiatrist	Multicare

Select providers - drag and drop to create Mary Poppins Care Team

My Client List


Home Notifications Client Search Profile Assessments ▼ Progress Notes CCP Data Manager ▼

Home

My client lists

--Select List-- ▼

A-c ✕

Add client (by MRN or last name): Search

<input type="checkbox"/> Name	MRN	DOB	Go to
<input type="checkbox"/> Poppins, Marytest	0000001017	01-Nov-2013	<input type="text"/> ▼

Progress Notes Notifications

Note(s) requiring your co-signature 0

Draft Note(s) 0

Group Note(s) to be completed 0

CCP Notifications

Issue(s) requiring your co-signature 0

This shows patient list assigned for each Care Coordinator

Health Action Plan Summary

<u>Issues / Needs Title</u>	<u>Domain</u>	<u>Goals</u>	<u>Goal Status</u>	<u>Last Modified By</u>	<u>Last Modified</u>	<u>Time Limited</u>	<u>Client Goal Priority</u>	<u>Clinician Goal Priority</u>
<input type="checkbox"/> Met with PCP/member/ Care Coordinator and husband December 18th at 3pm.	Prevention & Wellness (PRV)	Long term goal - Lose 50 pounds this year. Short term goal - Go one more month without a drink	Complete	Kathleen Herriges. ADMIN	15-Nov-2013 8:21 PM		Medium	High
<input type="checkbox"/> Member is over weight.	Fitness/Exercise (FIT)	Long Term Goal - Lose 50 pounds in one year. Short term Goal - Lose 5 pounds per month.	In Progress	Kathleen Herriges. ADMIN	15-Nov-2013 8:08 PM		Medium	High
<input type="checkbox"/> Husband fearful and reluctant to attend Alanon meetings.	Caregiver Support (CAR)	Have husband attend at least one Alanon meeting that is planned for this Friday evening at the local library.	In Progress	Kathleen Herriges. ADMIN	15-Nov-2013 8:00 PM		Not a priority	High
<input type="checkbox"/> Psychotropic medication management by Dr. Thomas Jones. Appt scheduled for November 18, 2013.	General Behavioral (BEH)	Get member to first behavioral health appointment.	In Progress	Kathleen Herriges. ADMIN	15-Nov-2013 7:52 PM	✓	Low	Urgent
<input type="checkbox"/> Member admitted to Royal Albert Hospital on 11/9/2013.	Care Transitions Services (TRN)	Discharge from hospital with behavioral health support. PCP follow-up and Psychiatric referral. PCP wants to see member 7 days after discharge.	Complete	Kathleen Herriges. ADMIN	15-Nov-2013 7:45 PM		Not a priority	Urgent
<input type="checkbox"/> Appt with Dr. Chekov planned for February 2, 2014	General Medical (MED)	Establish and maintain PCP relationship.	In Progress	Kathleen Herriges. ADMIN	15-Nov-2013 7:44 PM	✓	Low	High
<input type="checkbox"/> PCP visit scheduled for Nov 11/14/2013 and member arrived and visit was done.	General Medical (MED)	Establish relationship with PCP and obtain referral for Psychiatry.	Complete	Kathleen Herriges. ADMIN	15-Nov-2013 7:40 PM		Low	Urgent

Apply Status to selected issues: Select One

Care Plan Fields

Issues/Needs Title	Mary needs transportation to volunteer at humane society
Domain	Transportation (TPS)
Goal Status	In Progress
Last Updated By	Care Coordinator Name RN
Last Modified	23-Aug-2013 5:38 PM
Time Limited	
Client Goal Priority	Medium
Clinician Goal Priority	Medium
Issues/Needs Details	Due to Mary's weight and the weight of her chair he has issues getting transportation except for medical appointments
Source	Care Coordinator Name RN
Goals	Long term goal: volunteering at Humane Society or Fitch Hatchery. Short Term goal:1- Locate transportation that will accommodate her weight and the weight of her wheel chair within 60 days 2- Fill out application to volunteer at Humane Society or Fish Hatchery with in 60 days
Strengths / Resources	#1 Mary will contact the Humane Society for information on how to volunteer. #2 Mary will call C-Van for information on weight restrictions
Challenges	Mary needs more coaching related her weight issues. She had issues with transportation in the past and is frustrated with this subject. Mary's PAM score is 56.4 level 3

Resources

State and Federal HIT Resources

Kansas Health Information Network (KHIN):

Laura McCrary, Ed.D., Executive Director - lmccrary@khinonline.org
<http://www.khinonline.org/>

Lewis and Clark Information Exchange (LACIE):

Mike Dittmore, Executive Director - mike.dittmore@lacie-hie.com
<http://www.lacie-hie.com/>

Federal HIT website:

<http://www.healthit.gov/>

Including how to implement EHRs:

<http://www.healthit.gov/providers-professionals/ehr-implementation-steps>

Independent HIT Resource

Synōvim Healthcare Solutions, Inc.

Erin Patrick, RHIA, Technical and Quality Services Manager –
info@synovim.org or erin.patrick@synovim.org

Address: 2947 SW Wanamaker Drive, Topeka, KS 66614

Main: 785-273-3031

Website: www.synovim.org

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 Homes: A Member’s Experience
- May 27 – Health Promotion
- June 17 – Targeted Case Management (I/DD)
- June 24 – Health Homes for Primary Health Care Providers

**Thank you for
participating!**