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Kansas Medicaid Health Homes Initiative

Learning Collaborative

MARCH 16, 2016
ROLLING HILLS ZOO CONFERENCE CENTER
SALINA, KS



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Welcome!



WICHITA STATE
UNIVERSITY

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Center for Public Health Initiatives



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AD ASTRA PER ASPERA

Kansas

Department of Health
and Environment

Trauma-Informed Transitions:

Building Organizational Resiliency





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Introductions

Joyce McEwen Crane, PhD, LCP
Community Engagement Institute

Learning Objectives

- * Understand the role stress plays in transitions at the individual and organizational level**
- * Understand the impacts of stress/trauma at the organizational level**
- * Learn the principles of Trauma-Informed Systems of Care and how these principles can be used to create organizational resilience**
- * Create an initial plan of action for a trauma-informed, resilient transition**



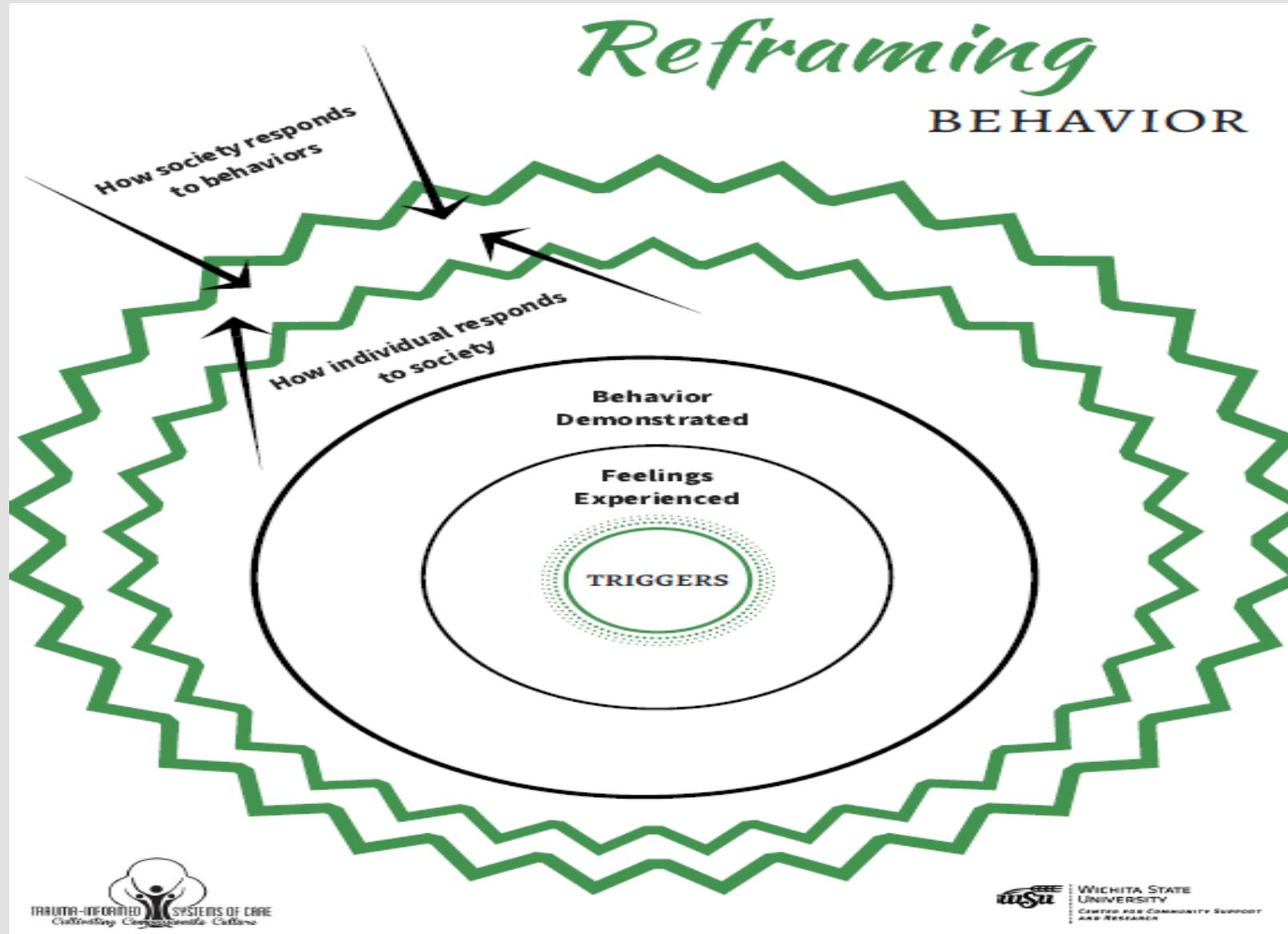
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Understanding stress



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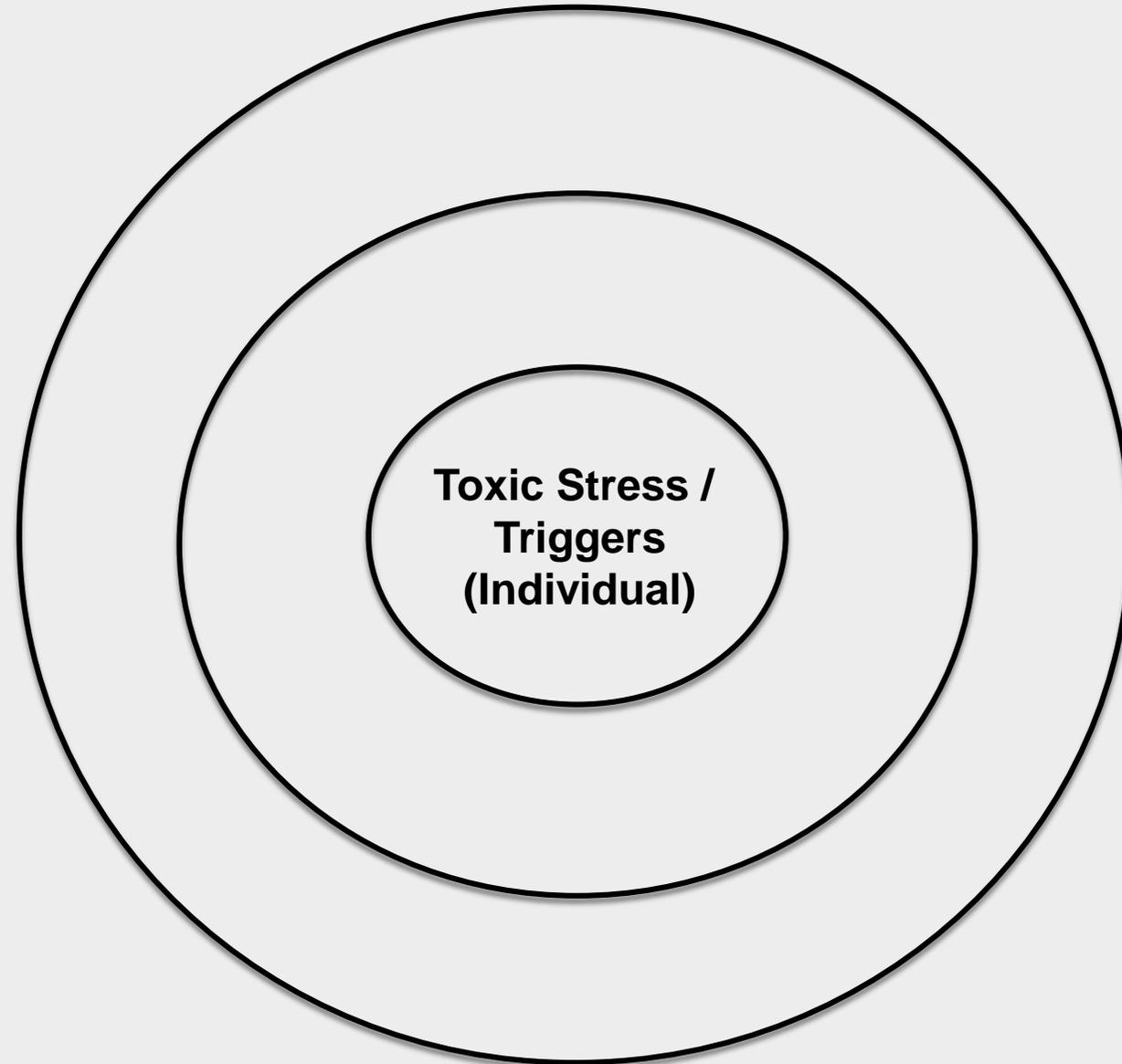
Effects of Stress/Triggers





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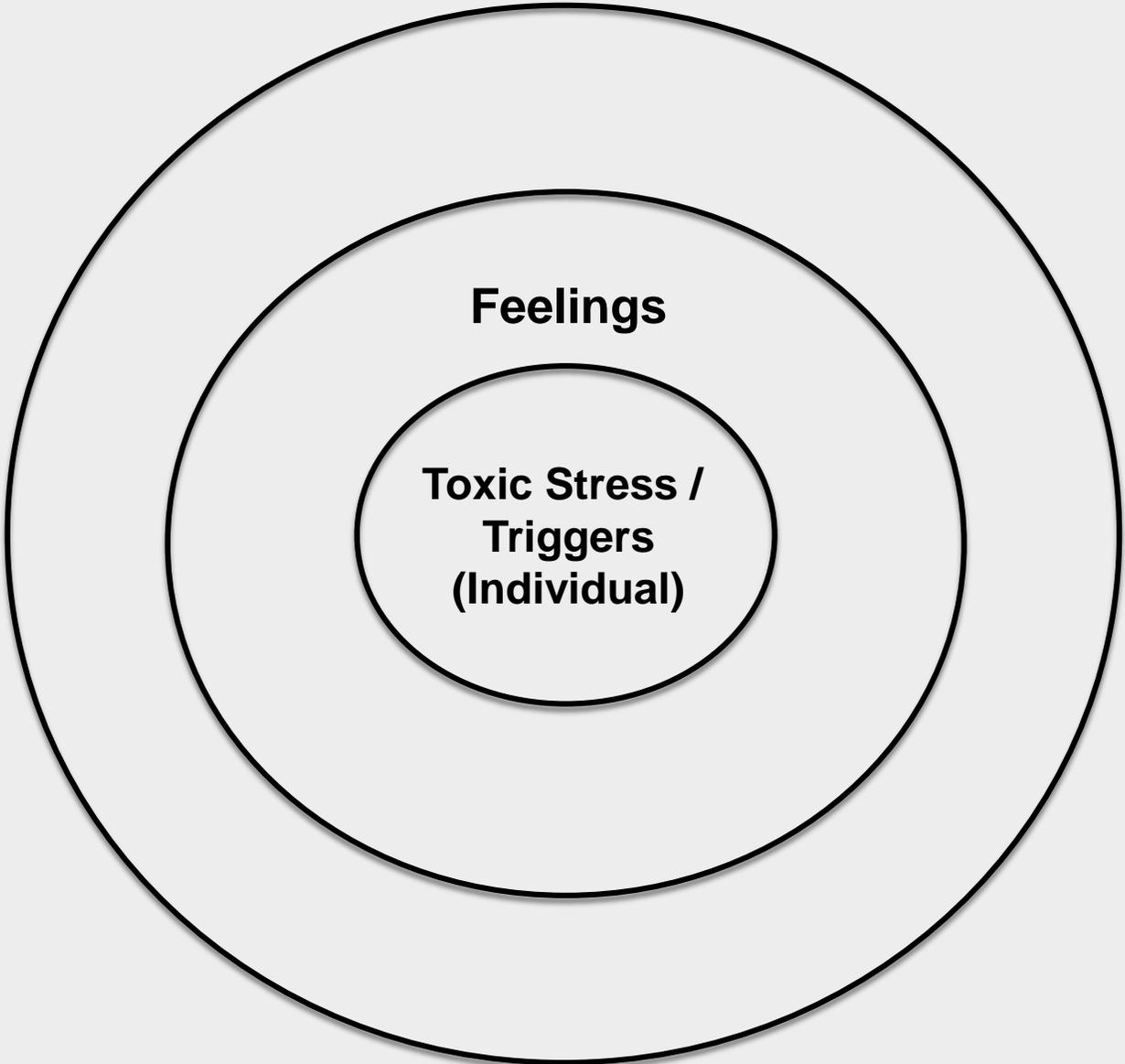
Understanding Stress



Understanding Stress



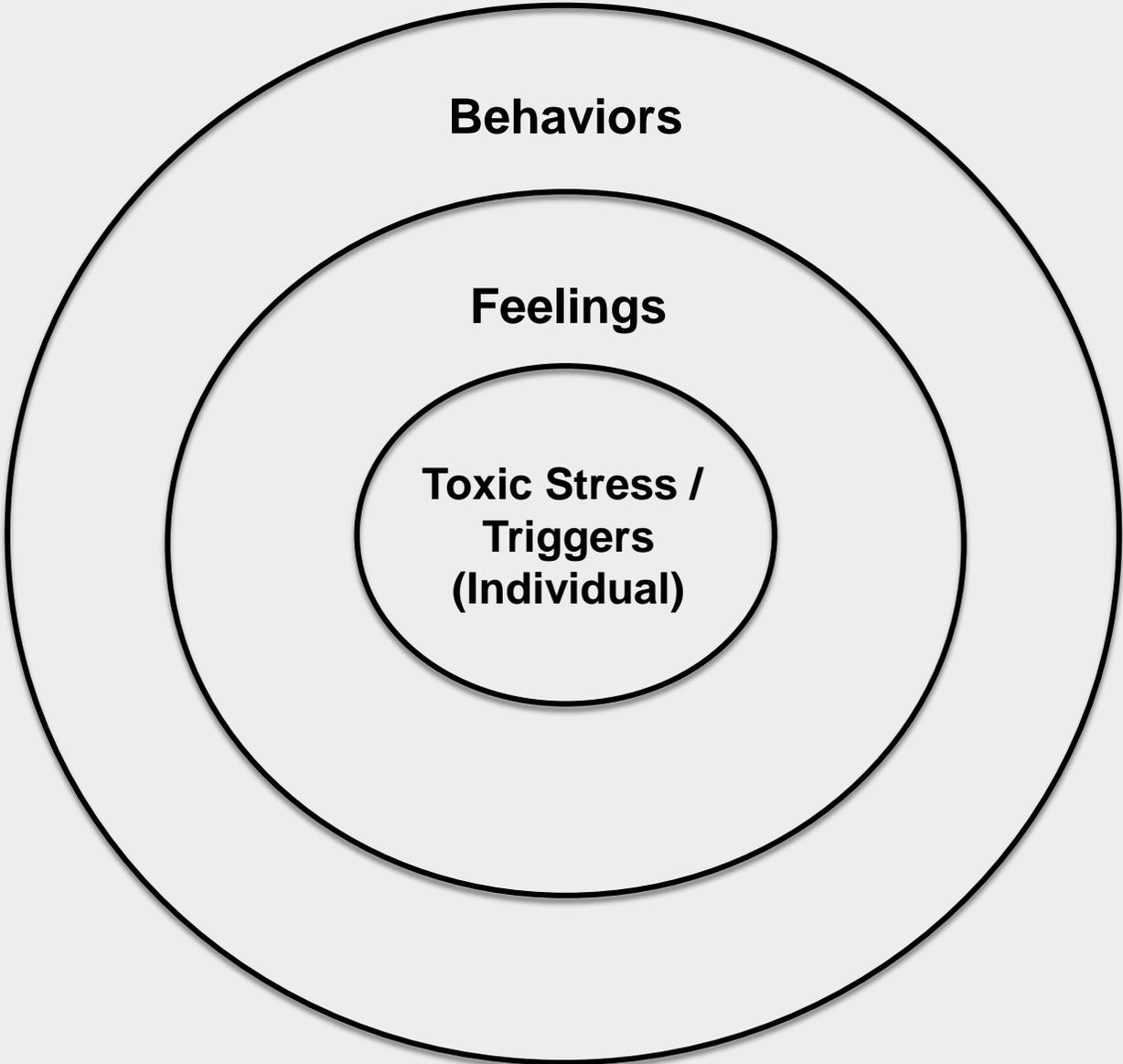
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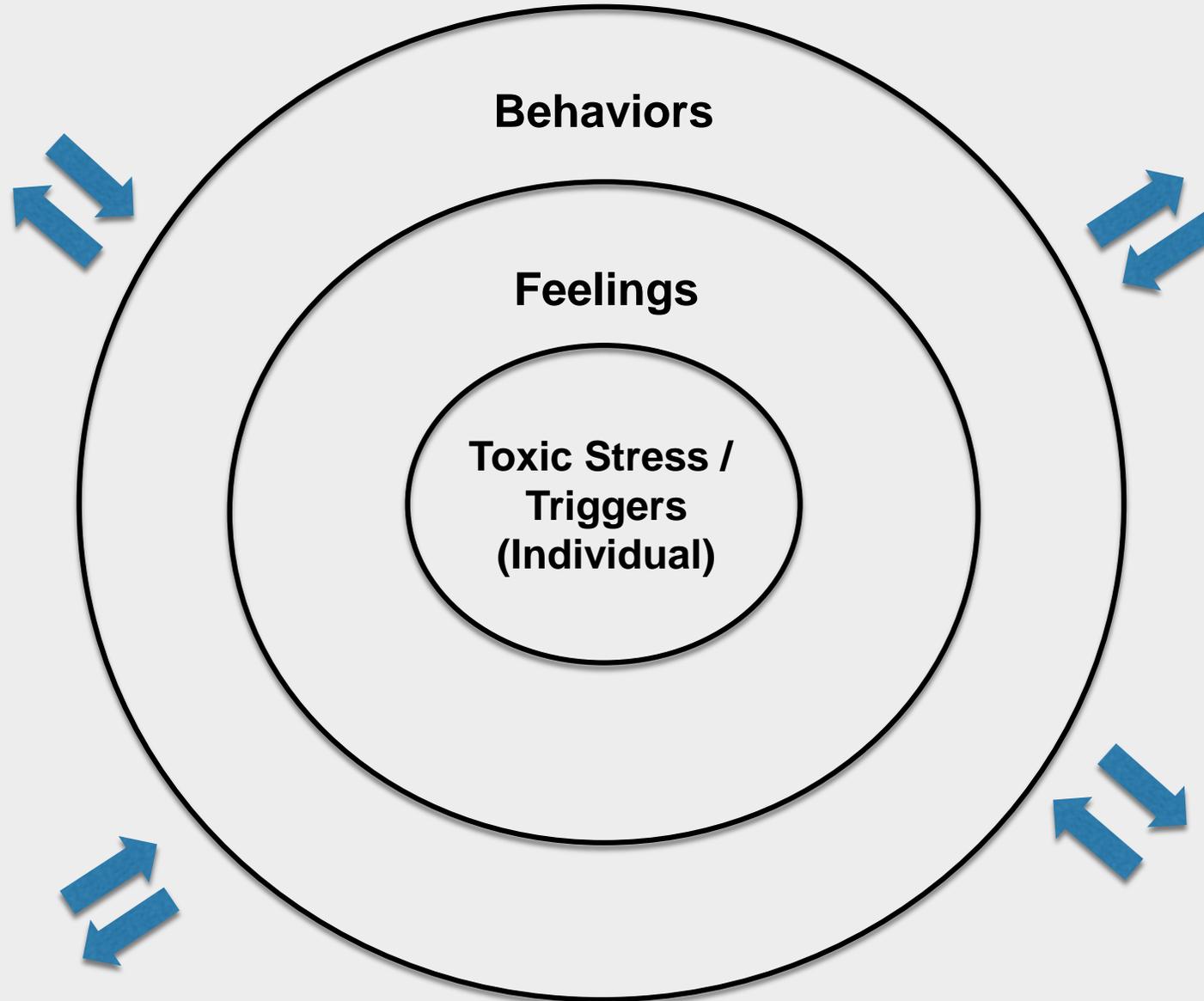
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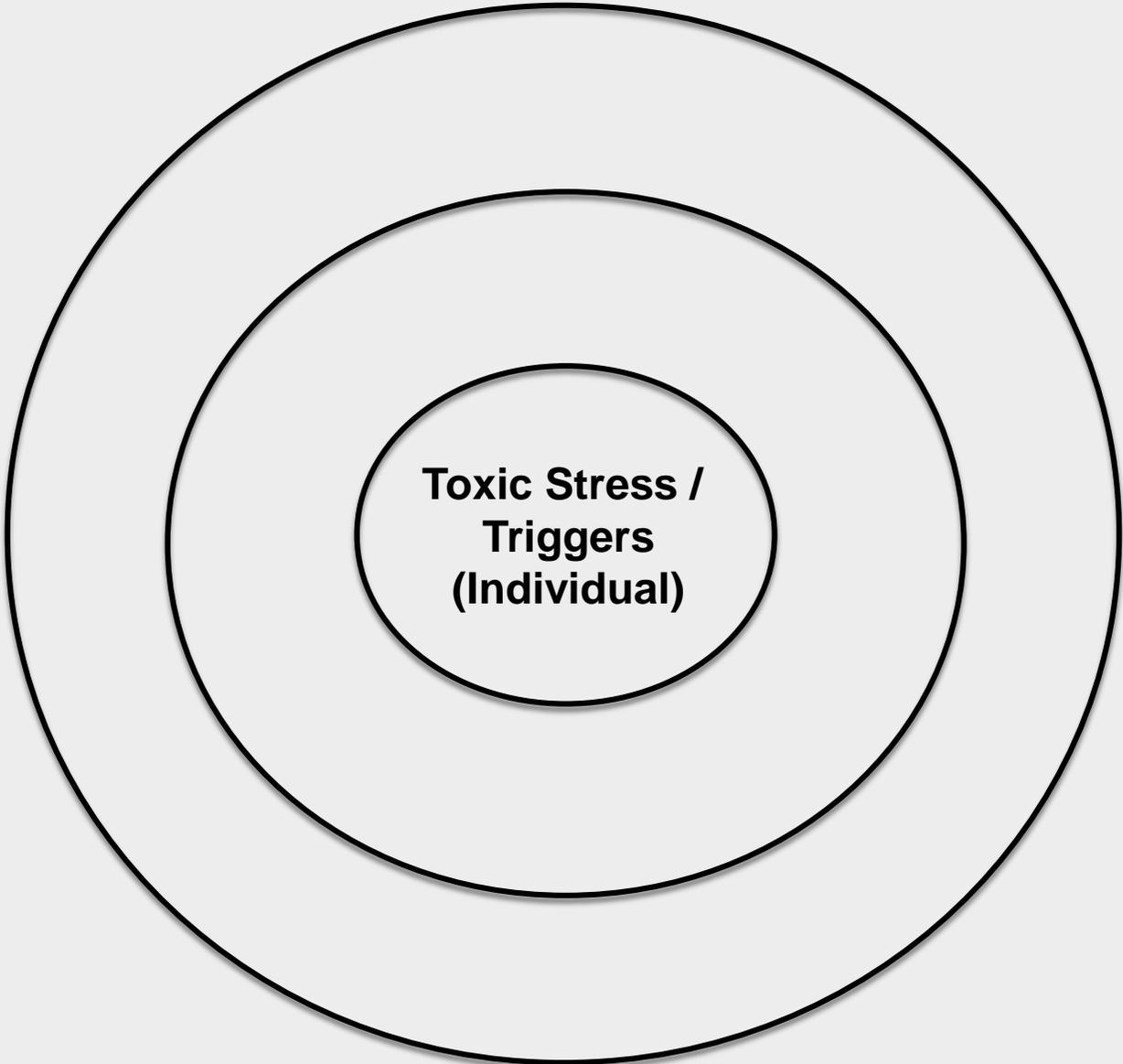
Understanding Stress



Understanding Stress



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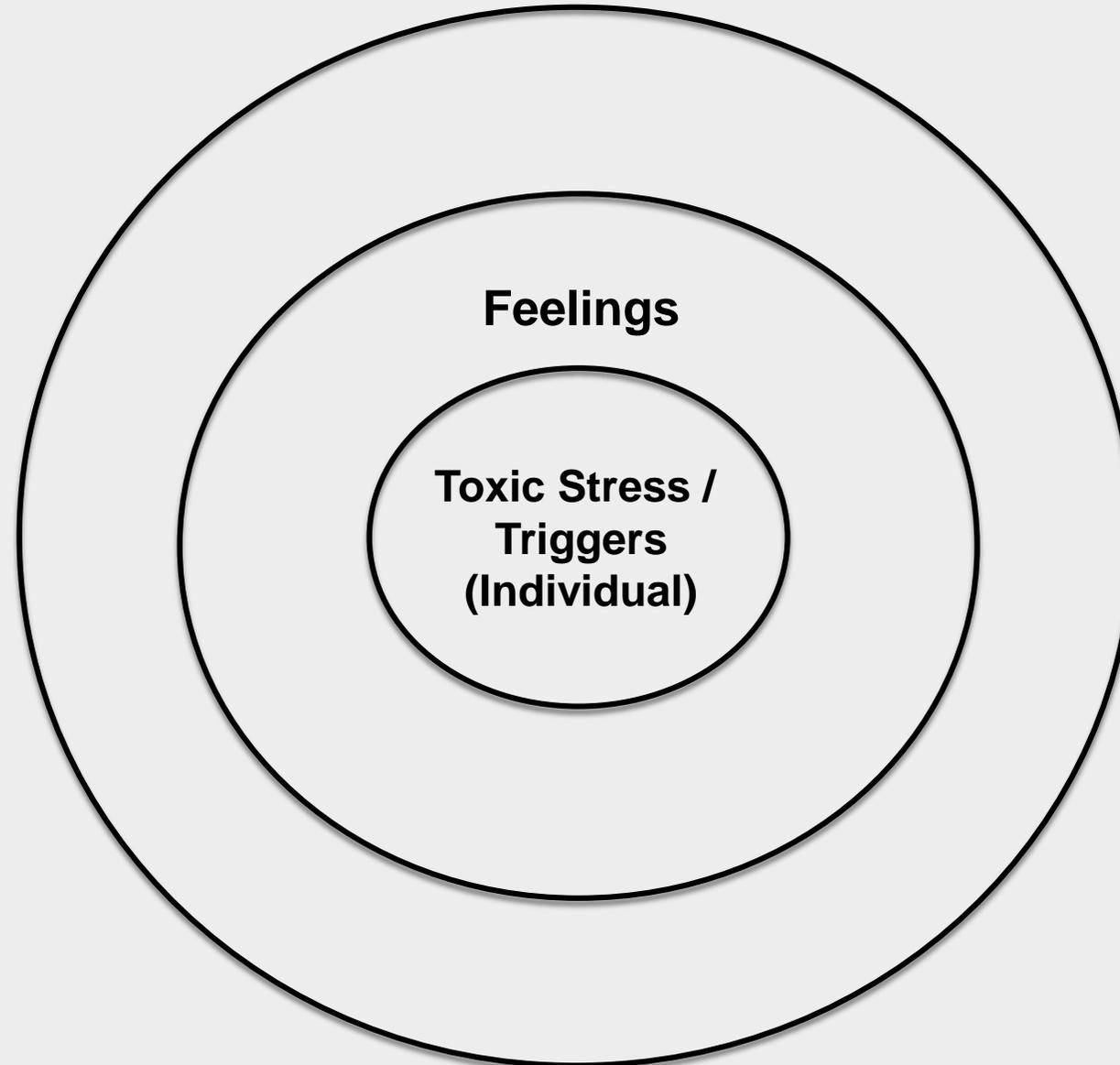


**Toxic Stress /
Triggers
(Individual)**



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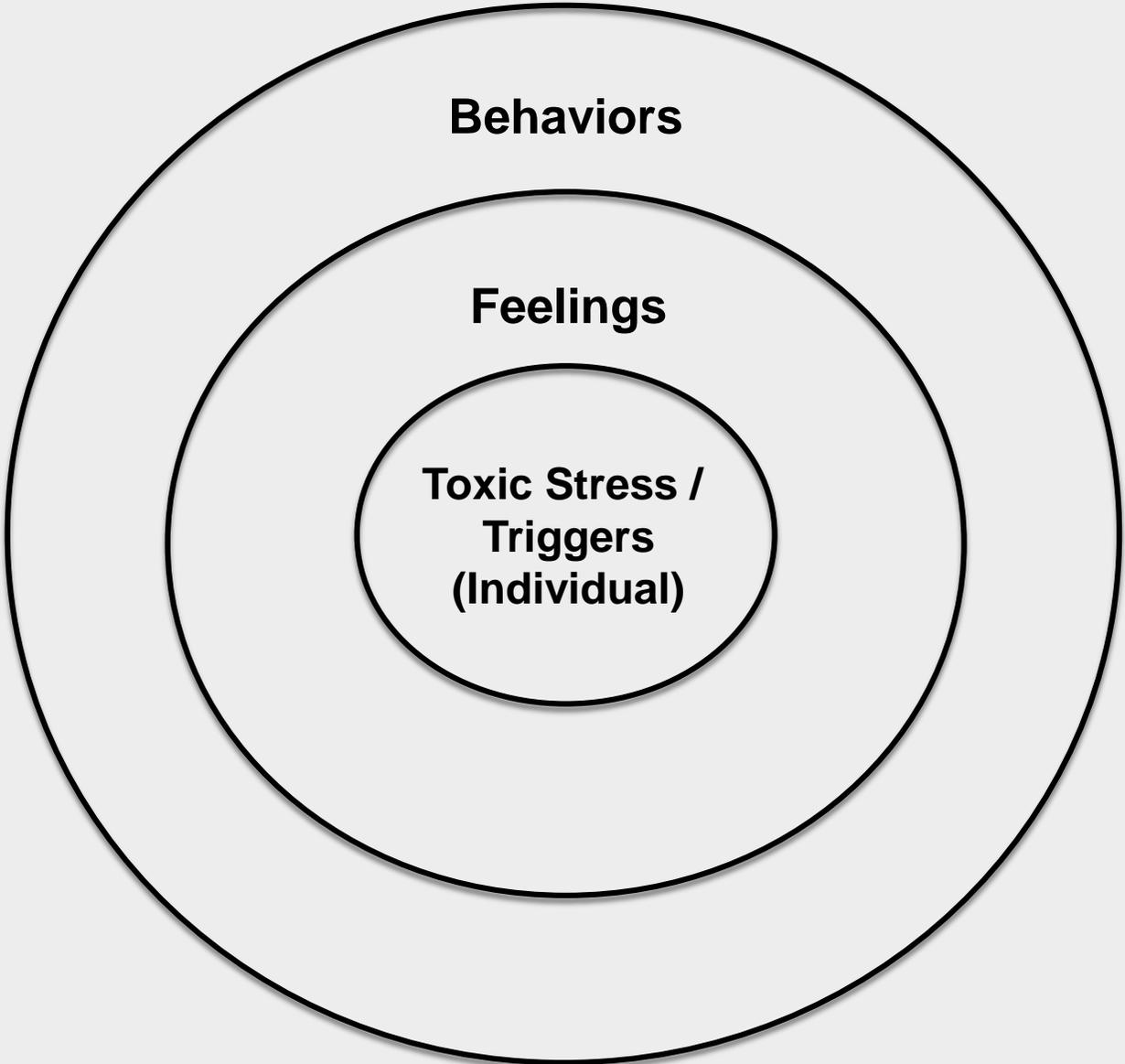
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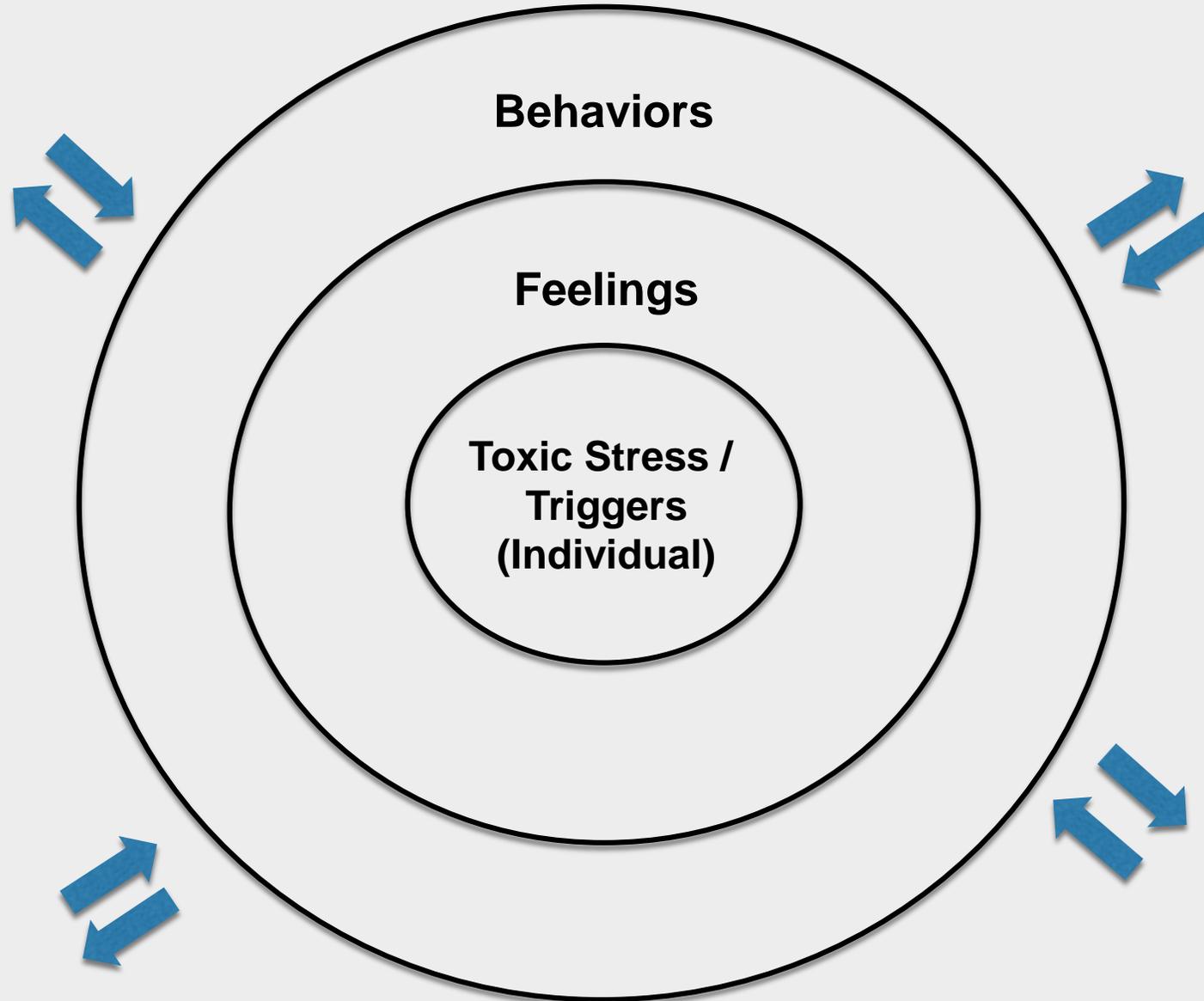
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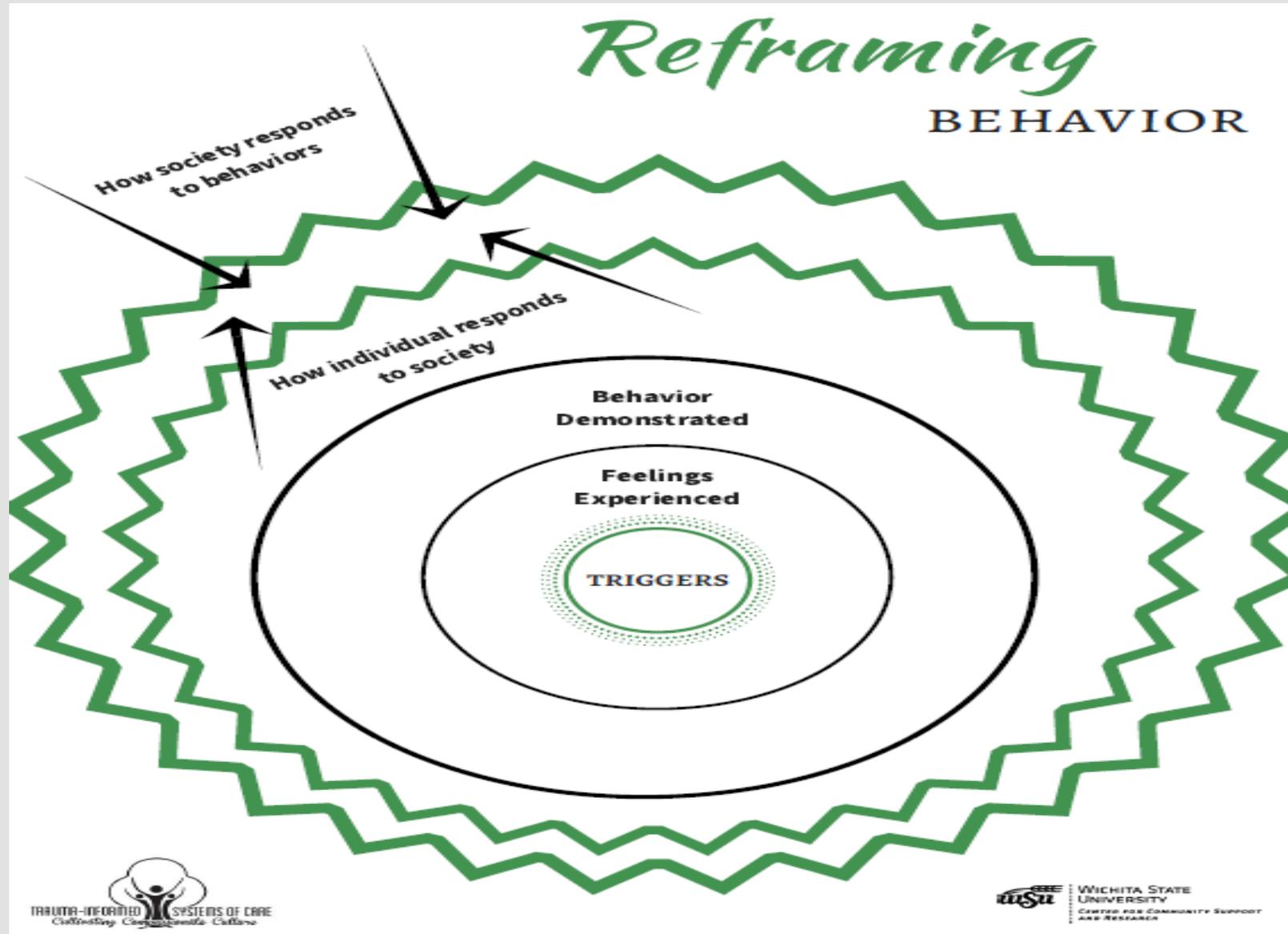
Understanding Stress





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Effects of Stress/Triggers



Discussion



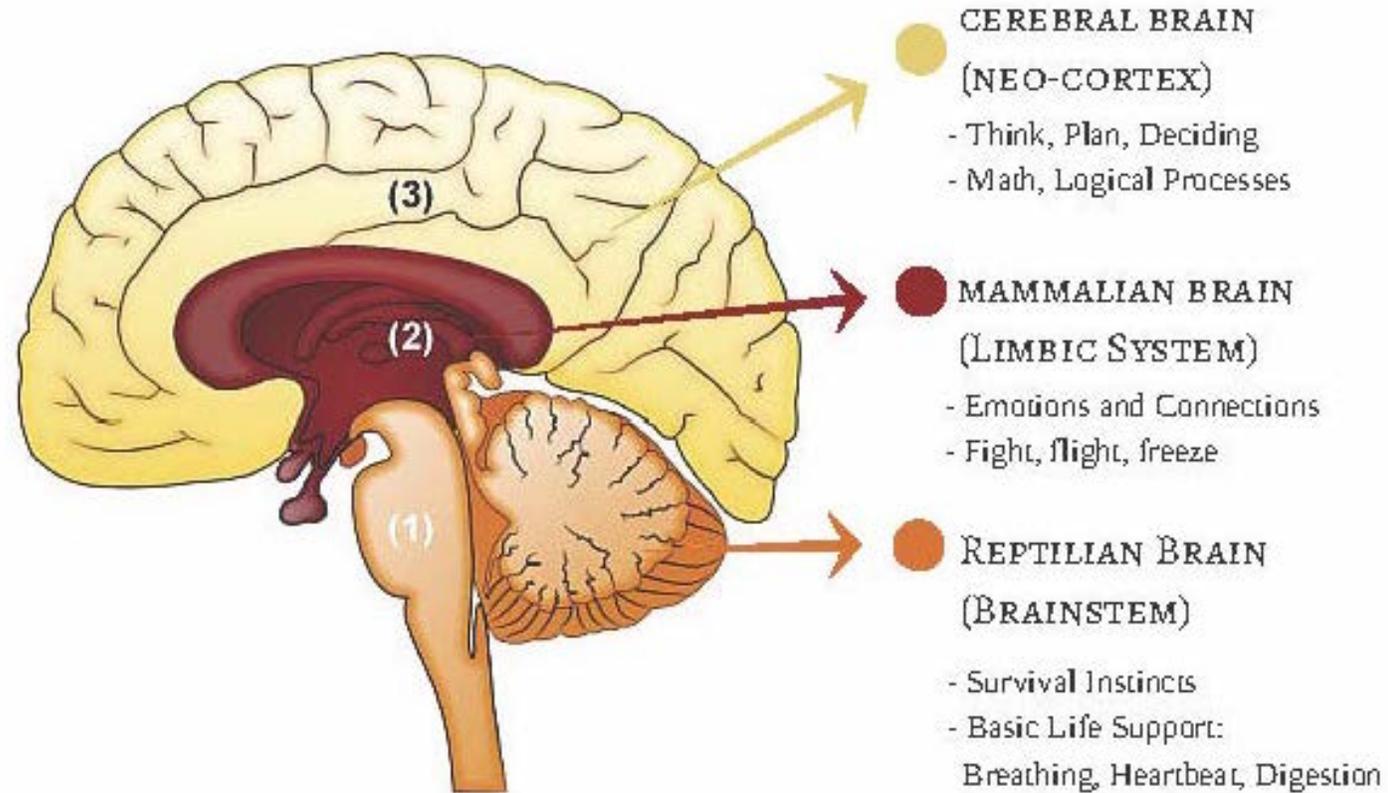
- * **Have an exploratory and honest conversation at your table discussing all of the possible, inadvertent ways that your system at work might be accidentally triggering people.**
- * **How has this exercise helped to frame stress or “triggers” for you?**
- * **What’s the connection to trauma?**

Trauma Defined

Experiences or situations that are emotionally painful and distressing, and that overwhelm people's (or organization's) ability to cope, leaving them [feeling] powerless.



Our Triune Brain



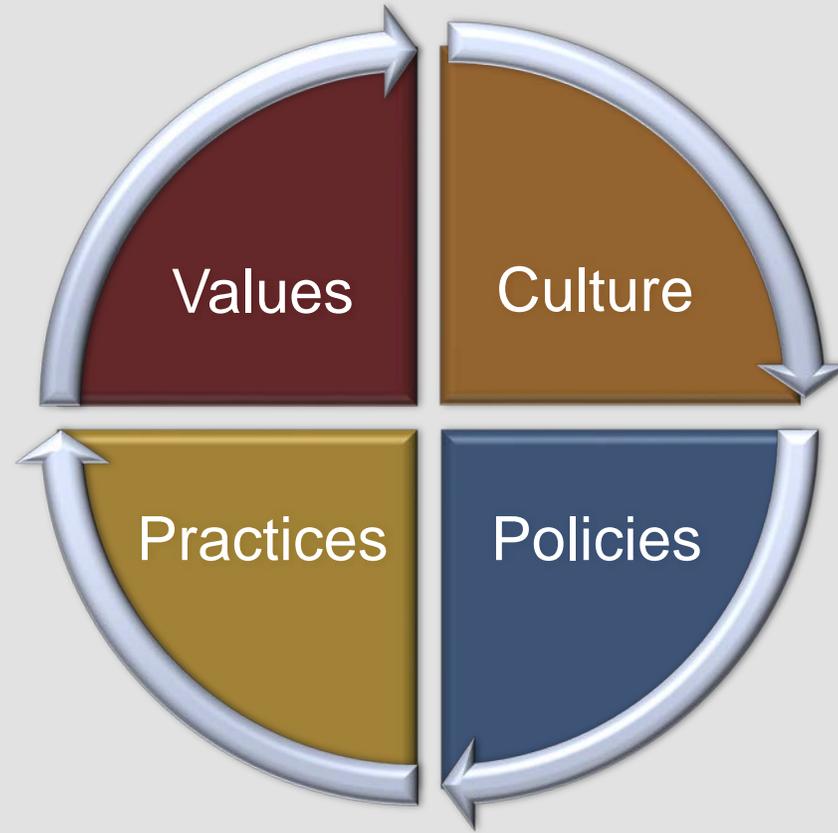
When your employees/ organization is dealing with trauma/toxic stress

- Experience PTSD or acute stress symptoms
- Protect or insulate oneself
- Become cynical
- Decrease productivity
- Call in sick
- Change jobs
- Experience problems in relationships
- Make mistakes or use poor judgment
- Blame clients or respond focused on pathology
- Over or under react in response to situations



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Trauma-Informed Systems of Care Align...





SAMHSA's Concept of a Trauma-Informed Approach

A program, organization or system that is trauma-informed:

1. **Realizes** the prevalence of trauma and importance of taking a universal precautions position
2. **Recognizes** how trauma affects all individuals, the organization & the system and workforce
3. **Responds** by putting this knowledge into practice
5. Resists **re-traumatization**

Principles of TISC

- * **Safety**
- * **Trustworthiness and transparency**
- * **Peer support and mutual self-help**
- * **Collaboration and mutuality**
- * **Empowerment, voice and choice**
- * **Cultural, historical, and gender issues**

**The environment we
create communicates
our beliefs about
[ourselves and] the
people we hire
and serve.**

-
- NATIONAL CENTER ON DOMESTIC VIOLENCE, TRAUMA & MENTAL HEALTH, 2011

The Looking Glass



Your Organizational Values

- **Identify values central to your organization**
- **Identify some values that are missing at your organization**
- **What are the ways your organization does and does not practice the TISC values?**
- **What might partners or persons served say about what your organization values?**

Cultivating more compassionate, resilient cultures

Resilience

Successful adaptation in the
face of risk and adversity,
despite status or challenges.



Strategies for Organizational Resilience

- * Build in consistency and predictability for clients and staff
- * Reframe negative behaviors/behaviors we don't understand
- * Debrief after incidences/Forums for staff support
- * Encourage self-care meaningfully (walk paths, exercise equipment, time off, etc.)
- * Create space (boards, posters) with theme of emotion and self-expression
- * Encourage/support individual choices and discuss consequences mutually

Strategies for Organizational Resilience

- * Anticipate (rather than react to) effects of changes
- * Teach staff affect management skills and practice them
- * Train staff regarding trauma-related affect, triggers and behaviors (staff and clients)
- * Train staff to tolerate emotional expression
- * Cue and support use of new skills
- * Review and adjust policy to align with TISC values and practices
- * **Social support is one of the most important resiliency factors—allow people to talk and provide support in their transitions.**

Strategies for Organizational Resilience (Leadership)

- Emphasis by leadership that staff stress management is essential
- Communicate clearly and often
- Ensure staff competencies
- Prevent staff from working long hours
- Provide ongoing supervision, support and access to EAP
- Create opportunities to demonstrate appreciation



What's the Plan?



What are some challenges you foresee unfolding as you consider a trauma-informed, resilient transition?

What are some opportunities you foresee as you consider a trauma-informed, resilient transition?



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Questions?

Joyce McEwen Crane

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What challenges are you facing when it comes to maintaining staff?

What does it look like for you to be “cared for” at work? For your staff?

What strategies might you use to care for and maintain staff?



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MCO Transitions

UHC Health Homes Program Individual Transition Plans (ITP)

March, 2016

Individual Transition Plan (ITP): Overview

- **Who?** The ITP is formulated and written for every *active and engaged* Health Homes member.
- **What?** The ITP is a written plan that is developed jointly by the HHP and the *active and engaged* Health Home member. UHC nurse care managers will provide guidance and support.
- **When?** ITP pre-planning may begin now.
- **Where?** The ITP may be developed telephonically unless it is an initial HAP: *all initial HAPs must be done face-to-face.*
- **How?** The ITP uses the existing HAP form to record customized transition plan and goals specific to the member.
- **Why?** The ITP provides for a successful post-Health Homes Program member transition while also providing assurance to both the HHP and UHC that the member is being adequately supported and managed.

Individual Transition Plan (ITP): Benefits

- The member and the HHP maintain and build upon their existing relationship in order to develop and write the ITP.
- The ITP retains the current Health Homes claims, billing and payment structure and costs.
- The ITP utilizes the existing HAP goals section for written specific transition goals.
- The ITP allows members to choose to remain in the Health Homes program through June, 2016 or to transition sooner.
- The ITP rewards those HHPs who have successfully engaged their members.
- The ITP reduces HHP workload as the Health Homes program heads toward closure. Health Promotion is the only HHP service required by UHC in June, 2016 although member may choose to receive others.

Individual Transition Plan (ITP) Specifics: May, 2016

- HHPs begin planning ITP for each engaged and active assigned member.
Note: “Engaged member” will be defined by State and MCOs.
- HHP and member co-develop ITP in May, 2016 (pre-Transition Month) via HAP form with specific written transition goals.
- The ITP HAP is signed by both the member and HHP; original is retained by HHP, copy is provided to member and UHC.
- HHP bills for Comprehensive Care Management for ITP HAP development as its primary Health Home service for May.
- ITP HAP development must be documented per existing protocols.
- Other Health Homes services provided in May should be documented per existing protocols.

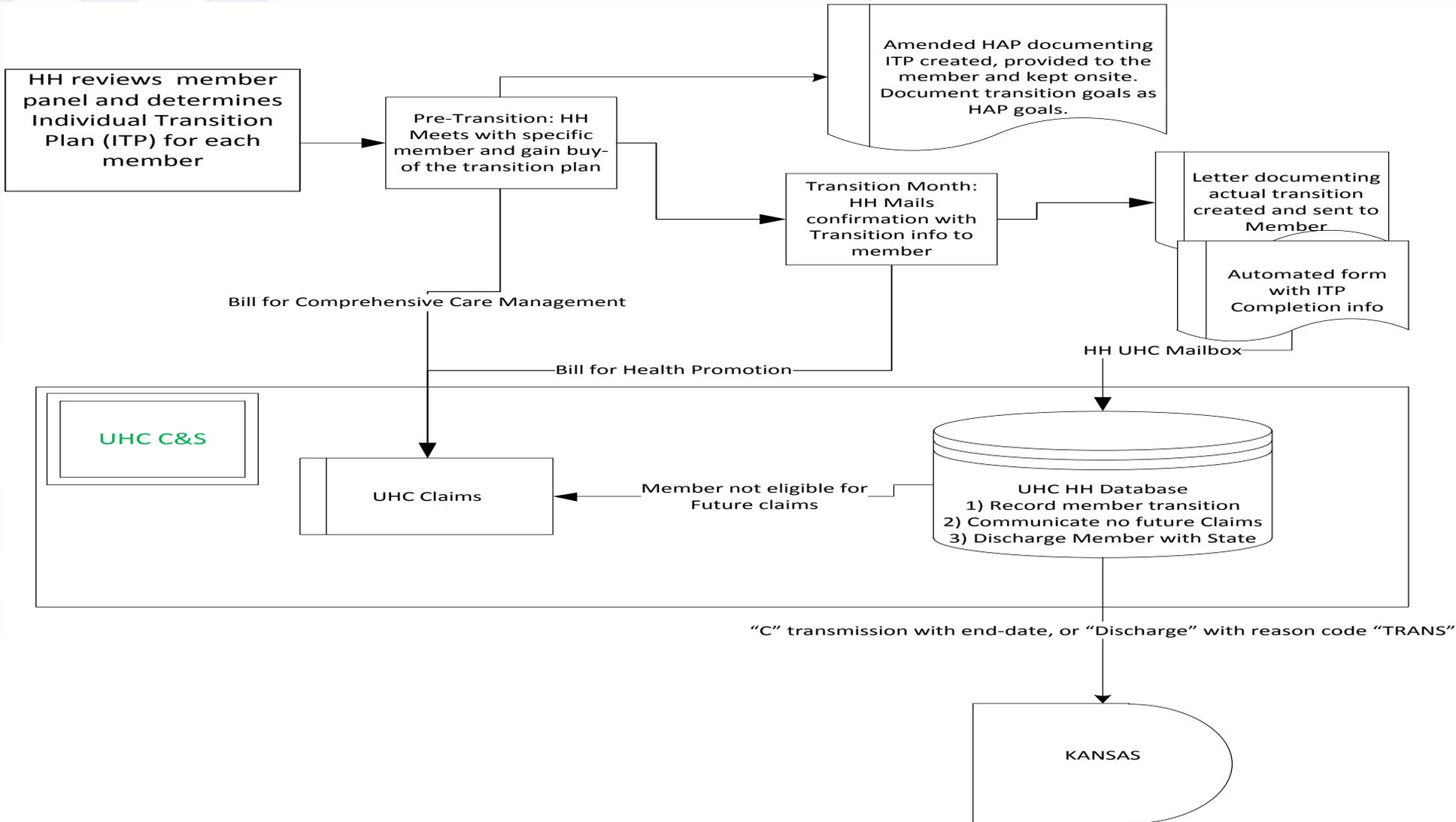
Individual Transition Plan (ITP) Specifics: June, 2016

- HHP sends final letter detailing the ITP to each assigned engaged member for whom an ITP has been developed.
- HHP bills for Health Promotion for this final letter mailing to member in June. This is the final billed Health Home service.
- HHP submits electronic form (to be developed) to MCOs detailing completion of the ITP process.
- No additional HH services are required of the HHP in June although the member may request additional services.
- This Health Promotion activity must be documented per existing protocols.
- Any additional HH services should be similarly documented.
- Final Health Promotion payment to HHP will be based upon member level at the time of service.

Individual Transition Plan (ITP): Additional Details and Next Steps

- MCO April member letters will include ITP information for engaged members; letters to unengaged members will exclude ITP information.
- Any member may request an ITP from an HHP.
- Successfully-transitioned members will be discharged from the program via a new code TRN which will allow State post-HH program tracking.
- An electronic form for ITP completion will be developed by UHC in order to capture ITP data.
- Compliance will be monitored via ITP HAP, documentation, and UHC's electronic form to be provided to HHPs.
- Need to define "engaged member."

UHC Transition Process Flow



HEALTH ACTION PLAN

SECTION IV. Existing HCBS Waiver Plan of Care (If applicable)

Do you have an existing HCBS Waiver Plan of Care? Select: Yes.

Plan type: Select: PD Waiver

SECTION V. Advanced Directives

Advanced Directives: Select : Yes.

SECTION VI. Goals and Steps to Achieve Desired Health Outcomes (Goals must address needs and must have measurable outcome)

Goal: To continue the supports and services provided by my HH provider after the HH program ends.

Steps to Achieve Goal: My HH CC and my UHC CC will meet with me by telephone to plan for my care coordination, services and support after the HH program ends.

Strength and Needs: My HH CC and my UHC are aware of my needs and I like working with them. I have a current Plan of Care developed by my UHC CC that meets my needs.

Measurable Outcome: My UHC CC and my HH CC will meet with me by telephone on May 5, 2016 at 10 AM to discuss my care coordination needs and transition plan.

Start Date: 05/05/16

Completion Date: 05/05/16

Progress (date): 05/05/16 My UHC CC is Kim Jordan, phone number 913-333-4190. She will meet with me on 05/10/16 at 10 AM at my home for a plan of care review and discussion of my needs.

Goal:

Steps to Achieve Goal:



Health Homes Transition Plan

Sunflower Health Homes Team

3/9/16



Goal



To facilitate a seamless closure of the Health Homes Program for Members and Providers.



Transition Plan



Health Home Providers

- Bi-weekly SMI informational teleconferences with State and MCOs with opportunities for Q & A
- Weekly MCO HH Workgroup teleconferences and follow-up information shared with Health Home providers
- Monthly SHP provider teleconferences and opportunities for Q & A effective February, March, April, May, and June.
- Encourage providers to remain in the program through June 30, 2016
 - Transition planning
 - Final Notification
- HHPs continue submission of monthly KKMAR



Transition Plan (continued)



Health Home Members

- Members will continue to be eligible to receive Health Home services through June 30, 2016
- Members may elect to change their Health Home Partner through June 1, 2016
- Member transitional HAP will include an outline of community supports and services to meet the member's physical and behavioral health needs prior to and after the termination of the Health Homes Program
- Members who lose their Health Home Provider due to early termination of the HHP will not be reassigned to a new Health Home Provider. SHP will make appropriate referrals based upon the member's physical and behavioral health needs



Transition Timeline



- April: SHP will mail letters to members the week of April 4th specific to their level of engagement
 - Engagement
 - unengaged members (members without a claim in the last 180 days)
 - engaged members (members with a claim within the last 180 days)
 - engaged IDD members (members with a claim within the last 180 days)
 - Each member letter will include primary care provider name and telephone number
 - Each member letter will include Member Services telephone number: 1-877-644-4623
- March – May: HHPs prepare transition HAP for engaged members and forward copies to SHP in a secure email to: LEN_SFSPHEALTHHOME@CENTENE.COM



HAP Transition Plan



- March, April, and May - HHPs meet (face to face or via telephone) with actively engaged members to discuss:
 - physical and/or behavioral health needs of the member
 - identification of community resources
 - member transition plan
 - contact information for new and existing providers

Services may be billed by the HHP under Comprehensive Care Management or Care Coordination



HHP Final Notification



- June - HHPs send final notification letter and a copy of the HAP to actively engaged members
 - Maintain copy of the letter sent to members in the member HHP files
 - Health Home services will not be reimbursed for services provided after June 30, 2016

June's letter may be billed under Health Promotion



SHP Post-Health Home Activities



- Health Home training for SHP staff to ensure team is ready to triage members who call for assistance
- SHP will make appropriate referrals based upon the member's physical and behavioral health needs:
 - Primary Care Providers and other Direct Service Providers
 - Nurtur Disease management
 - Waiver Case Management
 - LifeShare services
 - CBH/SHP Case Management





Amerigroup Kansas, Inc.

Health Homes transition plan

March 16, 2016



Transition plan

Amerigroup Kansas, Inc. is committed to an orderly and appropriate transition of participants as the Health Homes program comes to an end on June 30, 2016.

Transition plan, continued

- Communicate the status of the program to participants and Health Homes partners through Kansas Department of Health and Environment (KDHE) approved collaterals.
- Review and consider proposals from Health Homes partners wishing to continue to provide a service similar to Health Homes.

Transition plan, continued

- Review Health Homes participant data to arrive at options for follow-up care and services.
- Transition our Health Homes staff to an integrated care coordination department that will work with our long-term services and supports (LTSS), behavioral health, substance use disorder (SUD) and physical health case managers to support our most complex members in collaboration with our network providers.

Waiver and nonwaiver populations

- Amerigroup will collaborate with our waiver providers to coordinate services for members who are assigned to a waiver, consistent with the process prior to the implementation of Health Homes.
- For serious mental illness (SMI) members who are receiving community-based services from a community mental health center (CMHC) but who are not eligible for waiver services, we will work collaboratively with the CMHC, consistent with the process prior to the implementation of Health Homes.

Case management and service coordination

Our individualized care management and service coordination include:

- Physical health complex case management – obstetrics, pediatrics and adult.
- Behavioral health complex case management – serious emotional disturbance (SED), autism (AU), SMI and SUD.
- LTSS – traumatic brain injury (TBI), technology-assisted (TA), frail elderly (FE), intellectual and developmental disabilities (I/DD) and physically disabled (PD).
- Disease management centralized care unit (DMCCU) – disease management programs – 11 disease management program options to help control chronic conditions.

Physical health case management

Our case managers:

- Help members take control of their health care and get the most from their benefits.
- Assess, plan, coordinate and evaluate services to meet members' health needs.
- Develop member-centered goals for optimal health and wellness.
- Focus on self-advocacy – help members manage their health needs through education and support.

Behavioral health care

- Inform members about their illness or condition and engage them in their care plans.
- Facilitate an internal interdisciplinary approach to coordinate care and services between multiple providers and pharmacies to make sure the right care and services are in place.
- Connect members with community resources and supports.
- Recommend mental health, substance use and wellness services.
- Coordinate with physical health care managers, Health Homes case managers, Health Homes partners and LTSS staff to provide behavioral health expertise.

Long-term services and supports (LTSS)

- Complete a comprehensive needs assessment and person-centered service plan with the member.
- Understand the member's overall health and wellness goals to help them connect with natural supports that help them reach their goals.
- Help members understand and access additional services available to them in their community.
- Support members' physical, emotional and social goals by monitoring quality and consistency of services and helping resolve gaps as needed.
- Help members understand what they can do to stay healthy.

Disease management centralized care unit (DMCCU)

- Asthma
- COPD
- Diabetes
- HIV/AIDS
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Major depressive disorder (MDD)
- Schizophrenia
- Substance use disorder
- Bipolar
- Hypertension (HTN)

Connecting with Amerigroup

| | |
|--------------------------------|---|
| Member Services | 1-800-600-4441 |
| Amerigroup On Call | 1-866-864-2544 |
| Disease Management | 1-888-830-4300 |
| Service Coordination | 1-877-434-7579, ext. 50103 |
| Vision care – Ocular Benefits | 1-855-866-2623 |
| Dental benefits – Scion Dental | 1-855-866-2627 |
| Transportation – Access2Care | 1-855-345-6943 |
| TTY/TDD | 711 |
| Member website | <u>www.myamerigroup.com/KS</u> |



Resources for providers

| | |
|-------------------|--|
| Provider Services | 1-800-454-3730 |
| Provider website | providers.amerigroup.com/KS |

Kansas state resources

| | |
|---------------------------|----------------|
| Enrollment Center | 1-866-305-5174 |
| Eligibility Verifications | 1-800-766-9012 |
| KanCare Clearinghouse | 1-800-639-4777 |





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Looking to the future:
What will your agency/program
look like on July 1?

Looking back:
What have you learned as
an organization and as a
system that you will
take forward?



(tell your story)

Using words or pictures:

If you, as a leader in the process,
do a great job of managing the organization through this
transition...**how will you creatively tell the story of your
success to a future employer/supervisor?**

What would be helpful to receive from leadership (KDHE or the MCOs) over the next 3-4 months of transition?



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Mark your
calendars!

Learning Collaborative Webcasts

April 5 – 3:00 – 4:00 p.m.

Health Action Plan Webinars:

March 22 – Motivational Interviewing

April 26 – Understanding Health Literacy

May 24 – Smoking Cessation & the SMI
Population

All events are from 10:00 a.m. – 11:30 a.m.



Mark your
calendars!

Trauma Informed Systems of Care:

April 11 – WSU Old Town, Wichita

April 12 – KSAB, Topeka

April 14 – WSU Old Town, Wichita

May 9 – WSU Old Town, Wichita

May 12 – WSU Old Town, Wichita

May 20 – FHSU Robbins Center, Hays

May 26 – Holiday Inn, Salina

All events are from 9:30 a.m. – 4:30 p.m.



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Thank you!





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