

Health Homes Webinar
Health Action Plan: Step by Step
April 22, 2014

Presenter: Mary Ellen O'Brien Wright, KDHE Division of Health Care Finance

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Sonja: This is the next webinar in our Health Home series. These series will continue to be scheduled on the last two Tuesdays of each month through the spring and are intended to highlight tools and resources that are available to potential Health Home Partners. I'm Sonja Armbruster and we at The Center for Community Support and Research are supporting facilitation of these webinars. This webinar and all of the Health Homes Webinar Series Presentations are recorded for future viewing from the KanCare website. The slides for today are already posted to that site. The four webinars from February and March are available from the KanCare website now. For each webinar, the answers to questions raised during the presentation have been answered and posted. In a moment, we will give you a tour about how to locate materials on the KanCare website, but I wanted to alert you that during the regional meetings, we collected over 100 unique questions which have all been answered and posted on the website.

Just a few quick housekeeping items, all of your lines have been muted and will remain so for the entirety of the presentation. You should all have a question box that appears on your desktop as part of the GoToWebinar layout. If you can't to see it, you might see a red arrow and sometimes the box collapses so you can point to that red arrow and click. This will be our method for asking questions during the presentation. You may type your questions related to today's discussion at any time and our staff will theme these and ask them of the panelists at the end of the presentation. Because of the large number of people participating, we will not be taking questions via telephone. Please limit your questions to the topic of today's webinar. Any other questions may be referred to Samantha Ferencik and her email address will appear toward the end of the presentation.

Today's presenter is Mary Ellen O'Brien Wright from the Kansas Department of Health and Environment, Division of Health Care Finance. The purpose for today's call includes the following: increasing our understanding of who is involved and how to complete a Health Homes Action Plan and allow participants to ask staff from the Kansas Department of Health and Environment and our three Managed Care Organizations questions of clarification regarding the Health Action Plan. Mary Ellen will review access to the KanCare website resources, review the basics of the Health Action Plan, and include step-by-step completion of the Health Action Plan form, and review how to write quality goals. With that, I pass it to you Mary Ellen.

Mary Ellen: Thank you. Well regarding the website, if you go into the KanCare website and go down to the left hand side, you will see Health Homes and you click on that and it will take you to a screen that separates into "Consumers", "Providers", "Frequently Asked Questions" and "News and Events". Most likely most of you would want to click on "Providers" and from there it will explain each of the two State Plan Amendments or "SPAs"

as we call them, one for Serious Mental Illness, one for Chronic Conditions and we will also provide some information about the Health Action Plan, which we will be talking about today.

So some basics about the Health Action Plan and what it is: this is a tool that is specific to Health Homes and it's a tool to document the member's Health Home goals, the strategies to achieve those goals, who is going to be responsible for helping the member achieve those goals, or whether the member, him or herself, is responsible, and then the progress towards achieving the goals. It is going to be required for every member who is enrolled in the Health Homes. It will be developed by the member with the assistance of the Health Home Care Coordinator most likely and it will be in a face-to-face meeting for the initial development of the Health Homes and then for quarterly updates, which I'll mention a little bit later. It will also include input from all members of the Health Home team. As you know, the Health Home team doesn't just consist of the member and the Care Coordinator; there might be family members involved, other care providers, whoever they would like to be involved in this can participate.

As I mentioned, it should be updated at least quarterly and during those quarterly updates...and it can be updated more often if you want, but at least quarterly, it should reflect the status towards achieving the goals, including what the current needs might be, the effectiveness in improving or maintaining the health status, and other circumstances and this would be the place too where, if for some reason a goal or a strategy isn't working, possibly to adjust it or potentially you might be eliminating a strategy or a goal because it's not working or because a member doesn't want to work on it anymore, but this is really meant to document the progress. I do want to emphasize though the Health Action Plan is not to replace specific treatment plans that are already in place or Person Center Support Plans that are in place, nor is this intended to be the full clinical record. This is really just about the goals or the basic documentation about of the progress towards meeting those goals. It is designed to capture critical information that can be shared with all providers who are involved with the member.

The Health Action Plan includes: demographic information, contact information, physical and behavioral health information, Home and Community Based Services waiver information, if that is applicable, advanced directive information, and again if that is applicable, and then the Health Home goals and steps to achieve each goal, strengths and needs, that the person has measurable outcomes and of course, progress. This is a place, too where in the Health Home goals section, where there should be dates when something was achieved or possibly when another goal is added or eliminated. There is a signature page to indicate that people have participated in the development of the Health Action Plan or are reviewing it.

I mentioned the Care Coordinator – it's most likely that the Health Action Plan will be developed in conjunction with the Care Coordinator – the member and the Care Coordinator. The Care Coordinator would certainly be the one who is going to oversee the activities that the member is participating in and documenting that. The Care Coordinator would provide overall coordination of the plan including: assisting to determine the services that are needed, locating the needed services, ensuring that the member can access those services, (so do they have the transportation to get to a service), are they going to be able

to comprehend the information that is given to them or is somebody going to have to help them with that, referring for services, scheduling appointments and following up to see what happens, whether the member attended appointments, what kind of information that the provider can share.

The Care Coordinator would also be the person that would share information with all of the involved parties, so they are sort of the pivotal person to keep other members of the Health Home team informed and involved. They will monitor the emergency department and inpatient admissions to ensure coordinated care transitions and of course they will be documenting progress toward achieving goals in the Health Action Plan.

Now just to take a look at the Health Action Plan. As I said there is demographic information there at the top. This does involve drop down boxes, so in some cases you won't have to fill out anything, just click and it will drop down some information and you choose the correct one. It will have additional contact information so in that you would have whether there is a parent/foster parent/legal guardian involved, whether there is medical power of attorney, the KanCare MCO and the MCO Care Manager...I know they all call them something different, but that's just the general term for it, the Health Home Partner and who the Health Home Partner Care Coordinator is and then any other support person that might be involved.

Physical and behavioral health – again, this isn't necessarily a full record, but it's some of the basic information that will be entered into the Health Action Plan going into it prior to the development and then of course possibly changing as time passes. So you are looking at who their provider is, whether they've had a Kan-Be-Healthy Screen and, of course, that's only for children, the health risk assessment, the date that that was done prior to the development of the Health Action Plan, there will be a health risk assessment of physical and behavioral health that will be done. The physical health, what the diagnosis is and of course all of the basic information of height, weight, hemoglobin A1c, LDL, etc., whether the person is a tobacco user or not.

On the behavioral health side there will be the mental health diagnosis, whether there is substance use involved, whether a depression screening was done and then the results of any screenings that are done. Then on medication reconciliation, the name of the medication, the frequency in which it is given, who it is prescribed by and any additional information that needs to be in there about the medication. Does the person have a...does the member have an existing HCBS Waiver Plan of Care and again, there will be a drop-down box and you can just indicate yes or no and then what type. The same with an advanced directive – whether or not they have one.

The next section is the one we kind of focused on and it's what are the goals that the member has agreed that he or she wants to achieve and then the steps to achieving those goals. What strategies are going to be used to help the individual achieve those goals? There's a strengths and needs section and what can be included in there is what strengths does the individual bring to this and what are the needs, what needs to be added in order to help the person achieve the goals. And then what outcome that you're looking for from the goal or actually I think we are looking at filling that in when the person has achieved the goal. The start date and a completion date I had mentioned that and then progress with a

date will be down in the box below that. There can be as many goals as a person wants, probably fewer rather than too many might be best but boxes can be added in.

So just to give you an example of, you know, the goal would be an activity that will contribute towards improving the member's health and well-being, so we use a person named Earleen in some of our presentations so the goal being for Earleen to have a primary care physician to oversee her medical care. Then the steps to achieving that goal including who's responsible and what services will be provided, so from this particular case Earleen's Care Coordinator is going to assist her to choose a primary care physician and help her schedule her first appointment; the Care Coordinator is also going to attend the first appointment to help her understand the information provided by the primary care physician; the Care Coordinator is going to educate Earleen how to set up transportation through her MCO for future appointments, and the Care Coordinator is going to follow up with Earleen after each of her visits to ensure that she understands the information that the primary care physician conveyed.

The measurable outcome – how will it be determined that this goal was met? An example – Earleen will select a PCP, schedule and attend an initial appointment and then she will continue to see her PCP on a schedule recommended by the PCP. The Care Coordinator will also be documenting any progress towards meeting the goal. So with this example, Earleen selected a PCP from a list provided by her Care Coordinator and with the assistance of the Care Coordinator, she scheduled her first appointment. Her Care Coordinator took her to the initial appointment where she scheduled to see her PCP quarterly and knows how to arrange transportation through her MCO.

The final page in the document is the signature page. Certainly the Care Coordinator and the member's signature should be on there, and anybody else who participated in the initial meeting or any of the quarterly meetings after. It may be that there are some people, for example the PCP might not participate but would get a copy of this and can weigh in whether he or she has any other recommendations, additions or revisions in lieu of a signature.

I just wanted to mention that as we move on, we are working with the Bureau of Public Health here at KDHE so that we can get more information about Best Practices and evidence based practices to incorporate into the goals and strategies for the Health Action Plan, and also information about resources that might be available through Public Health to help people achieve their goals within their Health Action Plan. At this point, I think we will take questions.

Sonja: Excellent, thank you so much Mary Ellen and we have several questions in the queue, but this would be a great time to add your questions to the queue. We will take them in the order that they have come in for now. So the first question was: how do you envision the physician consulting participating in the Health Home Action Plan process? Would this be a primary function for that physician consultant?

Mary Ellen: With the physician consultant, in other words the one that is attached to the Health Home Partner, is that...?

Sonja: Yes, correct. So the physician that is attached to the Health Home Partner, what might his or her role be in the completion of the Health Action Plan?

Mary Ellen: Well I think potentially that person, that consultant, would be reviewing the Health Action Plans and again, weighing in whether he or she had anything else that they might want to add or asking any questions about the goals or strategies within the Health Action Plan.

Sonja: At this time, I would engage and encourage the Managed Care Organizations to go ahead and unmute and weigh in if you have additional answers to any of these questions. A second question that was asked is related to the quarterly reviews that you mentioned earlier. There are quarterly reviews for the Health Action Plan – is the expectation that those would be conducted face-to-face?

Mary Ellen: Yes, we do want them face-to-face.

Sonja: OK. Will the Health Action Plan be required to be completed when a client is difficult to engage, but has not opted out of the Health Home? So perhaps they have become...they have been assigned to a Health Home Partner and the Health Home Partner reaches out to the client, but the client doesn't respond – what is the suggested strategy in those cases?

Mary Ellen: Well yes, because the member is a part of the Health Home team and certainly their cooperation is expected, but yes they are expected to weigh in on the plan. If they don't...I might turn that over to the MCOs and see how they want to handle something if somebody doesn't cooperate in developing the Health Action Plan.

Sonja: So I know we have at least a couple on the line and for you MCOs, if you need to unmute, that's *6 to unmute (long pause). So we may come back to them.

Mary Ellen: I would say probably if something like that happens, the Care Coordinator would probably want to talk to the person about the fact that if you don't have anything that you want to work on or are not willing to work on, then possibly the Health Home is not the best place for you, but I still think it will be up to the member to opt in or opt out.

Sonja: Understood. It's clearly intended to be a collaborative process. On the form specifically, under Section 3 of the Health Action Plan, it indicates to fill in the "provider"...who is the provider?

Mary Ellen: The provider would be their primary care provider, whether that's a physical primary care provider or behavioral health – so it's one of those.

Sonja: OK. On the signature page, what signatures are required to be on the Health Action Plan?

Mary Ellen: Like I said, at the very least the Care Coordinator and the member and certainly anybody that's participated at the time the Plan was developed or at the quarterly

meetings should be on there. If they are not physically there to sign, as I said, it's possible that they have some sort of documentation that they saw it and that they...I don't really want to say agreed, but they at least had a chance to review the Health Action Plan.

Sonja: We have a question about the expectations related to the Comprehensive Assessment. So the full question is – could you speak more about the expectations of the Comprehensive Assessment to be completed prior to the Health Action Plan?

Becky Ross: This is Becky Ross and I will take that question. The state doesn't have a particular assessment. The MCOs have all done some health risk assessments on most of these folks, so they would have the information available for you. Most providers are doing some sort of an assessment, so we would expect the Health Home Partner to have or collect that information and pull that together and then fill in the gaps with any other sort of assessment tool that would work. For example, primary care providers may want to do the simple depression screening, the PQH9 I believe it's called to make sure that they are screening for depression. So we don't want to be real prescriptive about that; we want you to use whatever tools you have at hand and as we go forward, folks will be sharing best practices and talking with one another about what may work better than something else.

Sonja: Thank you, Becky. Another question – for individuals who assess I/DD, HCBS Waiver Services...is it safe to assume that the Health Action Plan will become part of the Person Centered Support Plan for monitoring and follow-up by the TCM? I know we have a plan for additional conversation related to this in the future, but is there a short answer to that?

Mary Ellen: I think that maybe we were envisioning it the other way around. If there is something within the Person Centered Plan that becomes a part of the Health Action Plan then the Care Coordinator or member could indicate that they are going to be working on this, and it's going to be worked on through their Person Centered Plan and then of course would have to update what the status is quarterly.

Sonja: OK, thank you. There are a couple of questions that are related to the integration of the Health Action Plan and the electronic medical record. So one of those questions...and I'm hoping that we have an MCO who might be able to engage in this question – is the Health Action Plan editable? Will it be located in the MCO's system or in our own electronic medical record? (pause) So where does the Health Action Plan reside? Does it reside at the provider in their electronic medical record or does it reside in the MCO HIT system?

Jeanine: This is Jeanine at Sunflower, can you hear me?

Sonja: Yes thank you Jeanine.

Jeanine: We're still working through some of that. We are looking at our own Provider Portal and how, at least, I'm not sure if it would be the entire Health Action Plan or certain parts of it, but how to incorporate it onto our Provider Portal because we have some other secure client information out there and just how to incorporate the information of the Health Action Plan as applicable into our portal. So we are looking at that, but I don't have any

definitive answers right now because we're still going through that process and defining how that will be done and everything. But we are looking at that. So that it's available since the Health Home is a collaboration between Providers, we're looking at how to do that through our portal system.

Sonja: Thank you, that was helpful. Is there another perspective that would like to be shared? (long pause)

Mary Ellen: We were thinking it was to be...we definitely want this one to be used. We got a lot of stakeholder input as to what they want to see on the form and what they didn't want to see so we do expect it to be imported into probably the electronic health record at the Health Home Partner and to be able to be shared electronically.

Sonja: Thank you, Mary Ellen, and I'm not sure we mentioned but the actual form itself is available on the website now and it is a Word document that is editable, but how that integrates with your own electronic medical records system at the individual agency or with the Managed Care Organizations may be something that's coming forward. This was also related to another question related to the signatures – do those need to be actually handwritten signatures or would you accept signatures that are electronic signatures, perhaps already kind of a set up thing in the electronic medical record?

Mary Ellen: I think that we would be willing to accept those. There was a discussion on that and there was some discussion on the complications of using that, that's why we said that we would also accept some indication or some indicator that the Plan has been reviewed by one of the Partners and was signed off on. Certainly if that can be worked out, that's fine.

Sonja: So another question related to the signatures – is there a requirement about who exactly has to be the signer? Does it need to be the Nurse Care Manager and the consulting physician or are their requirements about who exactly has to sign?

Mary Ellen: Yeah, the Care Coordinator may be at the Health Home Partner...so that is one signature...the person who is overseeing that the Health Action Plan to be sure it gets carried out and that needs to be on there and the member's signature. Beyond that, no, we don't have anything definite on who has to sign off; it just depends on who ends up being involved in the Health Action Plan, who plays a role.

Sonja: Thank you. Here's another question related to face-to-face and building on our use of technology – would the use of telemedicine to complete a Health Action Plan to be considered face-to-face?

Mary Ellen: Yes, I think that we would consider that face-to-face.

Sonja: OK, excellent. I'm scanning questions for just a quick second...will patients assigned to the Health Home Partner need to be registered in our electronic medical records along with all documentation? Which may speak to how might patients be assigned to the Health Home Partner, which relates to how they would access their Health Action Plans? So the

question is: if we are completing our Health Action Plan, do they need to be registered members of the electronic medical record with a provider?

Becky Ross: This is Becky, and I'm not really sure what they mean by "registered members" of the electronic health record unless you are talking about consent. I think if you are with a Health Home Partner and you have an electronic health record, you should have the Health Home member in your electronic health records. You may not have all the pieces because you may not be providing all the care for that individual, but our ultimate aim is the complete sharing of the electronic information. So I would think that if you do have an electronic health record now and you're serving as the Health Home Partner for someone – for a member – that you would want their information in your electronic health record.

Sonja: OK, thank you. I will make this the last call for participant questions because we have answered all of the questions in the queue thus far, so are there additional questions from participants that you would like to type into the question box related to completion of the Health Action Plan and the roles of the various providers within that plan? (long pause) OK, well seeing that there are no further questions, I will ask one more – is there anything else you would like to add Mary Ellen or Becky before we close out our webinar?

Mary Ellen: No, nothing that I can think of.

Sonja: OK. On the screen you have contact information for the various MCOs and for the presenter today to be able to email your questions directly to those participants. In the future, or next week, we will be convening to talk about Health Information Technology Basics and you can see the upcoming webinars listed there throughout the month of May and the end of June and then we will launch July 1. Thank you so much for participating in today's webinar and we will be posting the answers to those questions along with the transcript from today on the KanCare website. Thank you so much and have a great day.