

**Health Homes Webinar Series:
Health Homes: A Member's Experience
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Vanessa: Thank you for joining us everybody and welcome to the Health Homes webinar series. This is Vanessa Lohf and I am a Project Specialist here at the WSU Center for Community Support and Research. I will be your moderator today. This week's presentation is going to highlight how a Health Home might work for a hypothetical individual. This webinar and all the webinars that we have done thus far are posted on the KanCare website and this webinar will be posted as well, sometime in the next few days. The slides for today are already posted there if you would like to pull those up and review those later, as well. In just a moment, Becky Ross will give you a quick tour about how to locate the materials on the KanCare website.

Just a few quick housekeeping items, all of your lines have been muted and will remain so for the entirety of the presentation. I also want you to be aware that after the webinar is over, you're going to receive a thank you email and it will have a quick survey that we would like you to take so that we can use your feedback to make sure that we are meeting your needs and that we are moving forward with this information. We're going to go ahead and let you know that there is a question box on the dock of your webinar screen. That's where you will submit questions. You are welcome to submit those questions any time during the presentation, but please limit those questions to the topic of today's presentation. Anything outside of today's topic will be gathered and given to KDHE later or you can contact Becky or Samantha Ferencik directly with those questions and their contact information will be available at the end of the presentation. I'm going to go ahead and turn things over to today's presenter, who is Becky Ross from the Kansas Department of Health and Environment, Division of Healthcare Finance. Good morning Becky.

Becky Ross: Good morning. Thanks, Vanessa. So today our goal is that you will come away from this particular webinar with a better understanding of how the Health Homes processes work and how certain services will be timed throughout the year for an individual. We also hope that you will leave with a better understanding of the roles played by the Lead Entities, the Health Home Partner and the member, and that you will have a better understanding of the six core services of how they might actually roll out in real life.

So just to remind everybody, we've got to types have Health Homes, one for people with Serious Mental Illness and one for people with Chronic Conditions. Each has its own program manual on the KanCare website. Today we are going to focus on Earleen and her experience with an SMI Health Home. We will talk about the six core services and how those are provided over the course of her first year in a Health Home. To simplify matters, we've kind of pared this down so we will talk about basically one service a month, obviously people will get whatever services they need, but we will focus on one just to show you how it might work. Remember that a minimum of one service is needed to trigger

payment.

As Vanessa said, this is our website and if you click on the link highlighted there on the KanCare website, then that will take you to the Health Homes website and if you click on the "Provider" box, you will get to a whole slew of information there and the informational materials for providers is the page that you're seeing there, but you'll that we also have the webinars and other things on the website.

So many of you know Earleen, we've talked about her many times. She's one of our hypothetical examples. She was actually our first person that we thought about in terms of Health Homes. She has diabetes, she has bipolar, COPD, and some other issues. She wants to be employed, she's been to the hospital a lot in the last year. So Earleen...and these are things to kind of keep in mind as we walk through the rest of the slides...Earleen sees several doctors, but she doesn't have a primary care physician at the present time. She does meet criteria for Social Security disability, she's getting SSI and so she is eligible for Medicaid and in January, she was assigned to an MCO. So she's in KanCare, she's eligible for Medicaid, she's unemployed, and living with her sister right now and they're not getting along real well.

So starting in July, Earleen gets identified as being eligible for Health Homes and that's based on both her bipolar diagnoses, as well as her diabetes and hospital admissions. So she is eligible for both Health Home target populations. However, because she has an existing relationship with her community mental health center, the MCO that she's with will default her to their SMI Health Home. So she will get a letter in July that talks about Health Homes and lets her know what her assignment is, give her information about opting out, but she decided not to opt out and she doesn't request a change in a Health Home.

So the Health Home Partner Care Coordinator is going to review her medical history and do a follow-up Health Risk Assessment. And note for our example here today, the Health Home Partner will be performing care coordination for Earleen in the Health Home. So during that Health Risk Assessment, Earleen learns that her services are going to be in addition to what she's already getting in KanCare so her Coordinator will help her understand that she's not going to lose any services by being in a Health Home. She will also gain an understanding that she is eligible for two types of Health Home. So she decides to remain with the mental health center because she is seeing a therapist there and is familiar with the agency.

In August, the Care Coordinator, the therapist, a Peer Support Specialist and Earleen and her sister sit down and develop the Health Action Plan, which is sort of the kickoff to everything else in Health Homes and that will help guide the care, they will set goals, and so forth. So Comprehensive Care Management is the service there that's being provided. The Health Action Plan goals and health information that are going to be shared with all of Earleen's providers through Health Information Technology – secure email or through an electronic health record that others can access, perhaps even up through the Health Information Exchange. We just have a note here to help remind people that a lot of the Health Home services can be provided or can occur without the member being present. But when you develop that Health Action Plan for the first time, the member has to be

present and then quarterly thereafter as you update it, the member has to be involved and present.

The Health Action Plan, just to remind you, you are going to set goals there with the consumer, with the member, that will be unique to that member. Then it will be updated as the member meets goals, or they need to be altered. So at least quarterly, the Care Coordinator and the member work together to update the Health Action Plan. Other team members can be involved in the process, but it's not a requirement that the entire team sit down formally and have a face-to-face meeting. Goals can be pursued by the individual or through part of a group, so there could be a support group or group therapy or other things going on that the individual might be involved in. So for this example, Earleen is going to pursue one goal per month initially.

Her first goal is that she is going to get a primary care physician, she doesn't have one, she has seen a lot of doctors, she's going into the hospital, clearly she needs a primary care physician to help guide her care and make sure she is seeing the right specialists and so forth. So her goal is that she will get a primary care physician, she will also attend all of her appointments with her therapist at the Health Homes Partner at the CMHC. So the strategy to achieve this goal is that the Care Coordinator is going to assist Earleen in choosing a primary care physician, getting an appointment set up and Earleen is going to continue to see that primary care physician on a schedule that is mutually agreed upon between the PCP and Earleen. The Care Coordinator is also going to help Earleen in arranging non-emergency medical transportation for her appointments. So that activity is Care Coordination and that is what the Health Home Partner could bill for that activity.

Now we are in August, and Earleen's Care Coordinator helps her select that primary care physician, helps her get her first appointment scheduled, she signs a release to enable the Care Coordinator to get her medical information and the Care Coordinator helps her schedule her non-emergency medical transportation through her MCO. So following the visit, the Care Coordinator gets some information from the primary care physician so that the Care Coordinator can update the Health Homes records regarding Earleen. Earleen and her Care Coordinator schedule weekly appointments with the therapist at the CMHC or the Health Home Partner.

So now we are ready to work on another goal or to set another goal and Earleen's going to have increased understanding of her medical condition, her medications and her regimens necessary to treat them. This is all about helping her be involved in the management of her chronic conditions. She will follow the directions of her PCP and the specialists. The strategy is that the Care Coordinator will work with Earleen attending appointments if necessary, she may need to go to some of the specialist's appointments or other appointments. She will help Earleen understand what the PCP is talking with her about or information that the PCP has given her, as well as the specialists concerning her conditions and medicine. The Care Coordinator is going to help Earleen get connected to an online support group for COPD by using a computer at the local library. So there is a health promotion activity that can be billed for the month.

September gets us to...the Care Coordinator is working with Earleen to review the

information that the PCP has provided and working with Earleen to adjust the strategies in her Health Action Plan for Goal Two, so we are adding something to the strategies here so Earleen is going to take her glucometer to her PCP's office to download her glucose readings and have her medication adjusted based on those readings. One of the reasons Earleen is in the Health Home is because her diabetes is not well controlled so she's going to work with the PCP on that issue. Then the Care Coordinator is assisting Earleen in accessing that online support group.

So in October, we see some real progress here. Earleen's therapist is reporting that her weekly visits have been helpful, she's been experiencing fewer episodes of manic behavior or depression, and Earleen is telling the Care Coordinator that she has learned a whole lot from the online COPD support group and her COPD is interfering less with her everyday activity, so we are already seeing some progress on some of those Health Action Plan goals.

So now we are ready to set another goal and Earleen will have increased understanding of the long-term impact of her uncontrolled glucose levels. Now that she is taking regular readings and she has been sharing that with her doctor's office and getting a better understanding of that, then she understands the importance of that. To help with that, her Care Coordinator is referring her to a diabetes self-management program that's offered at the local health department and she will arrange some transportation for her. Since Earleen is nervous about this first session of the diabetes program, her Peer Support Specialist is going to go with her. So there is a health promotion activity again that the Health Home Partner can bill for.

In October, the Care Coordinator looks at the information from the diabetes management program to make sure that Earleen understands the material, Earleen is recording her glucose levels now through the MCO Member Portal or by phone with her Care Coordinator. Her levels and other information is now available for her Care Coordinator, the Care Manager at the MCO and the PCP to see in KHIN – the Health Information Exchange. Now Earleen feels comfortable enough that she can set up her own transportation through her MCO.

So we are into November and Earleen continues to monitor her blood levels and report those. Her medication has been adjusted several times as a result of the readings and now her PCP is recommending that Earleen start an exercise program and exercise regularly. So the Care Coordinator and Earleen make an adjustment to the Health Action Plan to include a goal of exercising regularly by walking. Here you see the goal that Earleen will exercise regularly and the strategy is that she is going to walk 15 minutes a day at least five days a week. Her Care Coordinator is asking that she keep a diary that tracks her exercise and her progress on this goal.

Now we are into December and because of the bad weather, Earleen ends up in the hospital. Her COPD is aggravated and she has to go into the hospital for some upper respiratory issues. So her Care Coordinator visits Earleen in the hospital and when she is released, she arranges to go home with her from the hospital and explain the doctor's orders to her, ensure that Earleen will attend the follow-up appointments, make sure that

she gets her prescriptions filled and helps her understand the importance of taking those medications. So this is all comprehensive transitional care which the Health Home Partner can bill for.

Now we are in January and Earleen is trying to get back on track after being in the hospital. The Care Coordinator sends the Health Action Plan to all of the providers that Earleen has for their review to see if there is anything that needs to be updated or modified as a result of her stay in the hospital. But the PCP reports that her blood glucose levels are improved and her A1c is reduced so we've got some good news. So she's made some more progress toward her Health Action Plan goals. She was able to maintain her blood levels within the normal range and her COPD has stabilized after she has come out of the hospital.

Now we are ready to set another goal and Earleen wants to move out – she and her sister are not getting along, as we mentioned at the beginning of this, and so she wants to find some affordable housing that is safe and has access to public transportation. The goal is to do that within six months. The strategy will be that her Care Coordinator will help her find some affordable housing on a public transportation route. So there we see a referral to Community and Social Support Services, which the Health Home Partner can bill for.

February comes and the Care Coordinator helps her fill out a low income housing application. The Peer Support Specialist works with her to learn the public transportation route in the area where Earleen is going to move so that she will feel comfortable using public transportation on her own.

Now we have another goal that Earleen is going to become more financially independent. Remember, she was relying on her sister for some budget and financial things so she wants to become more independent of her sister in that area. So the strategy is that the Care Coordinator is going to help her get signed up for some budget management classes at the local library and refer Earleen's sister to a support group for families of people with mental illness to help her sister understand Earleen's bipolar disorder. So there we have individual family support that the Health Home Partner can bill for

So here we are in April and we've seen more progress. She's been able to attend most of the budget management classes in March, she's actually created her own budget and is less reliant on her sister. She feels more comfortable with her budget and thinks that she can afford the housing that she has been looking into. Her sister now has some resources in coping with Earleen's SMI.

As we look into May, Earleen is now on a waiting list for the affordable housing, she's budgeting for that upcoming move and planning for that. Her Care Coordinator continues to monitor how well she's doing in maintaining her successes with all of the Health Action Plan goals. Once she becomes more stable in both her behavioral and physical conditions, the Care Coordinator will refer her to Voc Rehab to help her get some assistance in obtaining employment, because remember Earleen wants a job, and she will continue to work with her various providers on updating her Health Action Plan goals as she meets them. Now we are ready for questions.

Vanessa: Wow – thank you Becky – that was great. We do have a handful of questions that are ready in the queue but I want to invite those of you that are participating to please enter your questions in the question box on your dashboard and we will look at those and theme those as we go along. We want to restrict those questions to today's presentation, but I will let you know that we have folks...not only Becky from KDHE, but we do have folks from the different MCOs. Leslie Banning from Amerigroup is on the call, we actually have Jeanine Meiers from Sunflower State Health Plan, and Ben Pierce from United Healthcare. MCOs friends, remember that you can use *6 or #6 to unmute your lines if a question comes to you. Becky, the first question I have is a reminder to folks...where can they find the full definitions of the six core services on the KanCare website?

Becky: Well, there's several places, but probably the easiest is to grab one of the program manuals, either the SMI or the Chronic Conditions Program Manual, because the services are defined the same for both. There's a section there...there's a handy little table that lists all of the definitions.

Vanessa: Great, thank you. The next question I have is...early in the slides you mentioned that Earleen...one of the first things that happened was that she underwent a Health Risk Assessment. The question is: does everyone in the Health Home get this Health Risk Assessment? Then the follow-up question would to that is whether there is a standardized tool?

Becky: There is not a standardized tool. It could be a Health Risk Assessment, it could be some other sort of assessment. Essentially, whatever will give you the best picture of that individual's behavioral, physical and social support needs.

Vanessa: OK great. And the next question that I have is that you mentioned one of the opportunities for the Care Coordinator was to actually take Earleen to her primary care appointments and then again to visit with her in the hospital. The question that I have related to that is that considered double dipping? The fact that the Care Coordinator...

Becky: Well, I'm not sure why that term was used...

Vanessa: As far as paying the Care Coordinator and paying the PCP?

Becky: Oh, I see. Remember that Health Home services are bundled, so essentially the Health Home Partner is only going to bill for one service per month in order to get that monthly PMPM. So certainly if the Care Coordinator is actually the...and it's unlikely to happen...if the Care Coordinator were the primary care physician or the primary care provider, then it might be if they are visiting them in the hospital. But in this case, the Care Coordinator is at the community mental health center and their role is to work on that comprehensive transitional care plan. So it's not just about visiting Earleen in the hospital, it's about making sure that the follow-up appointments get made and get attended, that the prescriptions get filled, and that Earleen understands what she needs to do as she comes out of the hospital. I think folks need to not look at these in pieces, but see them as sort of a bundle, even within the service. So if you read those service definitions for each of the

core services, you'll see that they are very robust and there are a lot of pieces in there, so you could be doing various pieces of a service and that would be your Health Home service for the month.

Vanessa: Great, thank you Becky. One more clarification about the Health Risk Assessment...you mention that there is not a standardized tool, but is there an expectation that everyone have some sort of assessment as they begin their services?

Becky: Yes, and I know the MCOs have talked with providers about an expectation generally that this will be done within 30 days of the member being assigned. Obviously if some Health Home Partners get a large number of members at the beginning...at the launch of the program, then it's going to have to be staggered a little bit. We will have some conversations with the MCO's about when it's appropriate for a Health Home Partner to stagger those assessments and when the expectation of getting it done within the first 30 days should apply.

Vanessa: Great, thank you. We don't have any other questions in the queue. I would like to invite you quickly, again, if you do have additional questions for Becky about what she presented today, please shoot those to us. In the meantime, I do want to make you all aware that we have two more webinars scheduled: the first one is next week and we will be having a presenter from the KDHE Bureau of Health Promotion to talk about resources for the Health Promotion Core Service. Then on June 17 we are going to have a webinar that focuses specifically on the role of Targeted Case Management for Individuals with Intellectual and Developmental Disabilities. The invitation for that will go out probably sometime next week, but the invitation for the Health Promotion webinar went out yesterday, so feel free to join us. Becky, I don't have any other questions, so I think we are finished for today. I would like to remind everyone that you will receive a survey at the end of the webinar. Please send that back so that we can look at your feedback and see how we can do things better. Becky, thank you very much for your time, MCO partners – thank you as well. I wish you all a good day.